Meeting the Health Equity Challenge: State Case Studies

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Meeting the Health Equity Challenge

This past year, state public health departments successfully mobilized to protect tens of millions against the HINI virus, but a much more insidious and intractable problem remains: How to reduce health disparities that exist within every state.

In recent years, a raft of studies have shown that health outcomes, whether it be average lifespan, infant mortality, or rates of chronic diseases, are closely linked to what the World Health Organization in 2005 first described as the “social determinants of health.” Income, education, race, environment, access to good housing and safe neighborhoods – all shape an individual’s chances for a long, healthy life.

It’s not a new notion. Social reformers like Jane Addams toiled early in the century to improve living conditions and economic prospects among immigrants in urban slums. Even more significant was the series of life-changing government programs that emerged from the Great Depression, WWII, and the civil rights movement. Social Security, the GI bill, FHA/VA home loans, Medicare, Medicaid, Head Start, WIC, Pell Education Grants – all directly or indirectly impacted the nation’s health.

Yet despite these and other programs, sharp differences still remain in the health prospects of Americans. That fact came through loud and clear in the 2008 PBS series, “Unnatural Causes: Is Inequality Making Us Sick?” Segments dealt with problems ranging from premature births among black women to the alarming rates of diabetes in Native American communities and the surge in depression-related illness among victims of plant closings in Michigan. Conclusion: The social environment in which we are born, live and work profoundly affects our well-being and longevity.

Reinforcing that message in 2009 was a major report by the Robert Wood Johnson Foundation Commission to Build a Healthier America. In making 10 recommendations designed to help more Americans live healthy lives, particularly people facing the biggest obstacles, the commission acknowledged that “building a healthier America will hinge largely on what we do beyond the health care system. It means changing policies that influence economic opportunity, early childhood development, schools, housing, the workplace, community design and nutrition, so that all Americans can live, work, play and learn in environments that protect and actively promote health.”

Dr. Paula Braveman, director of the Center on Social Disparities in Health at the University of California-San Francisco, says that the roots of the health disparities issue can be traced to the civil rights movement. But in recent years, she notes that “we’ve turned the corner to embrace the broader concept of health equity, which involves addressing the social determinants of health, including socioeconomic disparities.”
Another California health expert – Robert Prentice of the Public Health Institute – adds that the most important step that public health departments should be taking to prevent the chronic diseases that account for 80% of medical costs is to collaborate with entities beyond public health, such as redevelopment authorities. “It is absolutely essential to reach out to other agencies,” says Prentice.

Along with the incalculable toll in lives and stunted human potential, neglecting this broader approach to public health also means mounting economic costs. A 2009 report from the Joint Center for Political and Economic Studies estimates that eliminating health disparities would have reduced direct medical expenditures by nearly $230 billion in the 2003-2006 period. When you add the indirect costs of these inequities, the tab comes to $1.24 trillion.

**A public health priority**

All this evidence is beginning to affect strategy within the public health community. The Department of Health and Human Services’ Office of Minority Health (OMH) has developed a new National Plan for Action, which describes the status of health disparities in the U.S. and proposes 20 strategies for their elimination. A major focus: Greater collaboration among community, faith-based and non-profit organizations, academic institutions, foundations, and federal, state and local agencies.

Dr. Garth Graham, deputy assistant secretary for Minority Health, notes that progress among the states in reducing health disparities so far has been “mixed,” with some states committing significant political support toward that goal, while others have been sidetracked by budget pressures and conflicting priorities. “In addition, we are all faced with the challenge of trying to fix a health care system that is integrally linked to other factors, such as housing, education, and many other social determinants of health,” says Dr. Graham.

To increase momentum in reducing health disparities, Dr. Graham sees OMH’s National Plan of Action as a valuable tool in recommending an agenda of activities and priorities that states and local partners “can adopt and adapt.” The plan draws much of its content from ideas voiced during a series of regional meetings that OMH held from 2007 to 2009. “The vision for this plan was shaped by people in the community,” explains Dr. Graham, “and we are returning the plan to the community so that people can come together around priorities that they establish.”

Key allies with OMH in carrying out the National Plan, he adds, will be the directors of state offices of minority health and health disparities. Members of the National Association of State Offices of Minority Health (NASOMH), these professionals serve as catalysts in promoting health equity initiatives in their states. “I see us as leaders at the state and regional level in implementing the National Plan, as well as partners with national organizations like ASTHO (Association of State and Territorial Health Officials),” says Barbara Pullen-Smith, president of the board for NASOMH and OMH director in North Carolina. “Community empowerment will be one of the major focuses, as we encourage racial/ethnic minorities and tribal organizations to mobilize around their own health issues.”
How are state public health departments organized to promote health equity and what tools and programs are they harnessing in this effort? To help answer these questions, ASTHO conducted a 2007 survey of offices of Minority Health and Health Disparities around the country. The resulting “snapshots” of state efforts to reduce health disparities can be found in the Health Equity section of ASTHO’s Web site (http://www.astho.org/programs/health-equity/). Another survey is planned for 2010.

“What we learned from the first survey is that there is wide variety in how states are structured to address health equity,” says Sharon Moffatt, ASTHO’s chief of Health Promotion and Disease Prevention. “For some states, the response is a single individual residing in the office of chronic disease. For others, there’s a growing awareness that you need wide participation within state government to establish health equity as a priority in people’s minds.”

Adds Meenoo Mishra, ASTHO senior analyst for Health Equity: “Many states face serious budget problems, but some steps don’t cost money, such as making sure that the concept of health equity is a fundamental goal in a health department’s strategy.”

Besides the health equity surveys, ASTHO has also developed, with support from the HHS Office of Minority Affairs, the ten case studies found in this section of the ASTHO Web site. Based on interviews with directors of MH/HD offices, state public health officials, community leaders, and local health officials, the case studies describe strategies and programs in ten states: Arizona, California, Georgia, Massachusetts, Michigan, Montana, North Carolina, Ohio, Oklahoma and Virginia.

The case studies chosen to build out the 2007 “snapshots” were chosen very carefully. Factors that determined the states chosen included the diversity of the populations served, the strength of the office staffing dedicated to addressing health inequity, and the number of years that the office within the state has been in existence. Regarding state population diversity, there are several different groups to consider with regard to health inequity. The most prominent group confronted with health inequity in this country consists of African-Americans. Georgia, North Carolina, and Virginia were chosen because of the high percentage of African-Americans within those states. Asians-Americans were also considered and were an important reason for the selection of California. State efforts in addressing health inequity in Latino/and Hispanic populations were captured with Arizona and for Native Americans in Montana.

Ohio was selected due to the contingent of staff within the state health officer dedicated to addressing health inequity. Michigan was selected given the history of their department, founded in 1988, and their track record of work. Diversity of funding was also a consideration for the selection of North Carolina—one of the few states to integrate financial support on state level with both federal and non-government-related funding.

ASTHO chose these particular states not only to ensure geographic mix, but also to demonstrate the wide range of strategies, programs, and ethnic/racial populations served. Some states, for example, maintain long-established offices focusing on programs to close the health disparities gap, while others are in the midst of new public awareness campaigns to demonstrate the extent of disparities and the impact of socio-economic determinants on health.
Although the problems faced by these states vary significantly, certain themes emerged again and again in these case studies from state health department leaders:

- Make health equity an essential element in public health strategy.
- Embed the concept of health equity in all public health programs.
- Educate other state departments, from education to housing to transportation, on the impact of their policies on people’s health.
- Gather detailed data on subpopulations both to design and evaluate programs to reduce health disparities.
- Forge strong partnerships with community groups, foundations, corporations and local health departments to achieve health equity goals.

Such steps can pose daunting challenges at a time of lean government resources, but ASTHO Executive Director Paul Jarris urges that state public health departments must show leadership. “As a country, we clearly are getting more serious about health equity and are starting to see this issue as one that is important to all Americans, not just to the underserved. Now, we need to determine what works.”

**For more information on Health Equity issues:**

- Department of Health and Human Services Office of Minority Health: [http://minorityhealth.hhs.gov/](http://minorityhealth.hhs.gov/)


For Will Humble, interim director of the Arizona Department of Health Services (ADHS), “health equity” is essentially another term for good public health practice. “It is a matter of using reliable data to determine who is at risk,” he says, “and then targeting programs to meet their needs.”

Humble points to his department’s response to the H1N1 threat. When the virus first emerged in the spring of 2009, the ADHS surveillance network found that the state’s Native Americans were at a much higher risk for hospitalization and death, primarily due to such underlying conditions as obesity and diabetes. As a result, when the vaccine became available, ADHS doubled the allocation for Native Americans.

Explains Humble: “Working together with the Indian Health Service, we were able to get the vaccine out to our Native Americans very early, even though we had to meet such challenges as reaching people in remote rural locations.”

**Strategy for intervention**

As Humble sees it, health equity too often gets linked in popular culture or the media to issues of race, ethnicity or gender. For him, it is all about determining those segments of the population who are most vulnerable -- then designing the appropriate intervention.

His predecessors in the department shared that view when in 2006 they changed the name of the ADHS Center for Minority Health to the Health Disparities Center (HDC). Part of the Bureau of Health Systems Development, HDC serves as “a catalyst to remind all our operational programs about the importance of reaching out to higher-risk populations,” according to Humble.

Zipatly Mendoza, chief of HDC, says the issue of health disparities has clearly gathered momentum. “Our department’s leadership has been stressing the importance of considering the social determinants of health,” notes Mendoza, “and our strategic plan for 2008-2012 made it a point to cite reducing health disparities as one of its guiding principles.”

The strategic plan states: “Compelling evidence illustrates that health is determined primarily by the social conditions in which we live and work. Further, data show that illness and early death are higher among marginalized subpopulation groups. This unfair distribution in the opportunity to be healthy demands priority attention and a long-term commitment to work with other government agencies, communities and the private sector to reduce these inequities in health.”

**Setting the agenda**
Consistent with those goals, the department in October 2008 convened 27 senior managers to develop a strategic map for tackling health disparities, paving the way for new programs in such areas as nutrition, exercise and tobacco control.

Mendoza explains that this roadmap is part of HDC’s effort to build a health equity agenda. That work also involves conducting focus groups within ADHS, as well as building partnerships with community groups and local health facilities to get a clearer picture of population segments most in need of help.

HDC is working with the department’s Vital Statistics arm to develop user-friendly statistical profiles, including data on income, education and health indicators, for five groups: Hispanic/Latino, Asian/Pacific Islanders, African Americans, Native Americans, and White Caucasians. Priorities emerging from these profiles, such as prevalence of particular diseases or health threats like alcohol or tobacco use, will help shape future ADHS programs.

Mendoza also hopes to establish a health equity steering committee, consisting of about 25 representatives from ADHS, local health departments, and community groups, which will monitor the progress of programs designed to reduce health disparities.

**The value of partnerships**

The impact of forging such alliances is already evident in such programs as the ADHS Multivitamin campaign, which targets Latina women, age 15 to 25, a demographic group with a high risk of neural tube defects during pregnancy. Launched in late 2008, the campaign recommends consuming a daily multivitamin with at least 400 micrograms of folic acid.

This health information program started with virtually no funding, but soon gained support from several ADHS bureaus. Young people from the Hispanic community helped design tee shirts and a special web site to promote the campaign, and radio and TV public service announcements featured rock bands in English and Spanish. Moreover, the campaign has expanded to include messages on exercise, nutrition, and mental health. In the process, the HDC developed valuable ties with ethnic media, such as *Latino Perspective* magazine in Phoenix and Azteca America, which operates cable TV outlets in Phoenix and Tucson.

“This program serves as a good model for future collaborative efforts,” says Mendoza. Already, ADHS bureaus have come together to develop a series of quarterly health messages on such topics as obesity and tobacco use, which are sent to health providers for distribution to patients.

Meanwhile, HDC has developed a 500-name email list for its own announcements, including a quarterly newsletter that highlights community-based health programs, journal articles, grant opportunities, and conferences related to health disparity issues. This information campaign has helped solidify partnerships with influential organizations and local health centers.

In Yuma, for example, HDC partners with Campesinos Sin Fronteras (CSF), a non-profit organization that serves as a health and social services advocate for farm workers. Among its outreach activities, CSF hosts an annual December health fair that attracts more than 5000
people. Emma Torres, CSF co-founder, says ADHS has become much more active in reaching out to the minority community and has helped support not only the CSF health fair, but programs to control tobacco use and prevent teen pregnancy prevention. She also cites the importance of immunization and HIV control programs administered by the state’s Office of Border Health. Says Torres: “We need the continued support of ADHS, as well as agreement on priorities, rather than operating in silos when we are serving the same population.”

Zeenat Mahal, director of the Epidemiology Center at the Intertribal Council of Arizona, also believes that ADHS is doing its best to reach out to Arizona’s more than 20 tribes, though she worries that the state’s budget woes may lead to cutbacks in programs to control substance abuse and chronic diseases in tribal areas. Mahal gives the department high marks for emergency preparedness, especially the H1N1 response in the Native American community. “They are really working hard to make the tribes their partners,” says Mahal.

A similar message comes from Essen Otu, Diversity and Cultural Competency director for Phoenix-based Mountain Park Health Centers, which operates five clinics in underserved areas with large numbers of Hispanic, black and Somali immigrant clients. “There’s been much more activity and focus within ADHS on health disparities, and that has trickled out to the community,” says Otu. The ADHS Bureau of Behavioral Health Services helped shape the methodology that Mountain Park used for a health disparities assessment it made in 2009 of its own operations. That exercise included interviews, focus groups and surveys with staff, patients, and community members.

**Just a start**

Such testimonials aside, Mendoza sees plenty of challenges ahead. She stresses the need for better racial and ethnic health data, one of the priorities among Western states that make up Region 9 of the HHS Office of Minority Affairs. In her view, national standards are needed to replace the patchwork of data collection methods now used.

ADHS Director Humble agrees that that good data is the “cornerstone” of health intervention programs. He cites the importance of the federal government’s HITECH (Health Information Technology for Economic and Clinical Health) program, which is allocating $19 billion to develop electronic health records, including the integration of medical, public health, and mental health records.

Among other priorities, Mendoza is moving ahead with an online training module on federal CLAS standards (culturally and linguistic appropriate standards), which she hopes to post in several locations on the ADHS web site. That’s in addition to a full schedule of talks on health disparities that her office gives to community groups and to students in the health professions.

While health equity proponents worry that such activities are threatened by the state’s budget crisis, there’s a strong sense that Arizona has turned the corner in making health disparities a priority. “Just look at all conferences, workshops and articles on the subject,” says Otu of Mountain Park Health Centers. “The ball is rolling in the right direction; we just have to figure out how to do more than less.”
For more information on Arizona’s health equity initiatives:

Arizona Department of Health Services (ADHS)
http://www.azdhs.gov/

ADHS Strategic Plan FY 2010-2014

ADHS Public Health Services
http://www.azdhs.gov/phs/index.htm

ADHS Bureau of Health Systems Development
http://www.azdhs.gov/hsd/index.htm

Arizona Health Disparities Center
http://www.azdhs.gov/phs/healthdisparities/index.htm

Arizona Health Status and Vital Statistics 2007 Report

Get Moving Arizona
http://www.azdhs.gov/diro/getMovingAZ.htm

Healthy Arizona 2010
http://www.azdhs.gov/phs/healthyaz2010/execsum.htm
Despite a continuing budget crisis and the challenges of serving perhaps the nation’s most diverse population, California nevertheless has managed significant strides in reducing health disparities.

In 2009, for example, the California Department of Public Health (CDPH) cited progress on several fronts—

- Reported cases of tuberculosis dropped to 2,695, the lowest count ever recorded. CDPH, along with local health departments, conducts an ongoing program to quickly identify the disease, as well as to treat affected individuals and isolate them if needed. New immigrants account for half of new TB cases.

- The Surgeon General’s office awarded the “Healthy Youth for a Healthy Future Champion Award” to CDPH for its Healthy California campaign. This outreach program encourages low-income families at some 10,000 community sites to eat healthier foods and get more exercise.

- Routine HIV testing in high-risk areas, such as inner city communities, has become more widespread, thanks to new legislation that removes barriers to such testing in treatment centers where people seek regular health care.

Yet as encouraging as these developments are, obstacles in reducing health disparities in California are daunting, especially for a public health department that has lost the equivalent of 15% of its workforce as a result or mandated three-day furloughs each month to cope with the budget shortfalls.

“In Los Angeles County alone, over 220 languages have been identified,” says Laura Hardcastle, chief of the CDPH Office of Multicultural Health (OMH). “The work becomes even more complex when you consider the need to serve people in areas ranging from sprawling cities to remote rural counties.”

A “Key Indicators of Health” report released by the Los Angeles County Department of Public in June of 2009 underscores these challenges. It found that residents of the South and Metro Service Planning Areas, which have the highest rates of poverty, reported the least safe neighborhoods, the lowest access to healthy foods, the greatest barriers to medical care, and among the highest rates of disease.

“Again and again, we see that unhealthy living conditions place the most vulnerable segments of our population even more at risk,” said Dr. Jonathan Fielding, director of Public Health for Los Angeles County. “These findings highlight the stark health disparities seen in the county and the
need to not only increase access to medical and social services in underserved communities, but also to work across public and private sectors to improve the physical, social and economic environments in which we live.”

**Designing a framework**

That message is echoed by Dr. Mark Horton, CDPH director, as he describes efforts to create a new strategic framework that makes health equity part of the essential fabric of his department. “The next wave in improving health outcomes in communities depends on progress in leveling the playing field in health care,” says Dr. Horton. “That means that health equity must be the filter we use when we think strategically about how to construct new programs.”

In the state’s campaign to reduce health disparities, the Office of Multicultural Health services as the principal coordinator on health equity matters across five major CDPH centers: Chronic Disease & Health Promotion, Infectious Diseases, Family Health, Environmental Health, and Health Care Quality. In addition, OMH works closely with the Office of Women’s Health, whose landmark California Women’s Health 2007 shows the great diversity in health care needs of women, as well as issues that are unique to the state, such as border-area human trafficking that amounts to slavery.

Goal 1 in the CDPH’s current strategic plan is “to increase quality and years of healthy life, reduce disparities, and promote health equity.” Moving forward, Dr. Horton wants the action plan of each center to address health equity, a plan that is consistent with the agenda of the HHS Health People 2010 goals. Among other things, this new framework will stress more “upstream” or “causal mapping” of health problems to identify opportunities for making policy changes, including a greater focus on prevention.

Along with representatives of other CDPH centers and the National Public Health Leadership Institute, Hardcastle is completing a year-long evaluation of the department’s efforts in health equity, including an extensive survey of nearly 90 different programs. Results of this assessment will form the basis of a report and recommendations in 2010 for the CDPH executive management team.

“Reducing health disparities is a very complex issue that requires moving away from a public health model of silos devoted to particular specialties,” says Hardcastle. “We need a much more broad-based approach.” She hopes to see the establishment of an interdepartmental working group from across CDPH’s centers that would study health equity issues on an ongoing basis.

**Forging alliances**

That kind of cross fertilization is already occurring in California state government. CDPH participates with departments like housing and transportation in the Strategic Growth Council, a cabinet level committee that coordinates the activities of state agencies on issues ranging from air and water quality to affordable housing and public health. Outside of state government, too, CDPH works with organizations like the California Endowment, which funds long-term programs to encourage healthy communities.
Another working group that cuts across many departments, including CDPH, Housing, Social Services, Mental Health, Alcohol & Drugs, and Corrections, is targeting another serious health equity issue – the disproportionate number of minority children in foster care. With the support of the Annie E. Casey Foundation, the group is investigating not just the makeup of foster care rolls but the social and economic factors that put so many Native American and Afro-American children in foster care. Says Hardcastle: “A whole range of agencies must come together to help these children and reduce foster care numbers.”

Another key ally for CDPH is its own Council on Multicultural Health, made up of 21 members from organizations representing racial and ethnic groups, as well as from universities and local health providers. The opinions of the council weigh heavily in CDPH policy and have been incorporated into the design of programs dealing with HIV-AIDS, tuberculosis and obesity.

One Council member, Martin Martinez of the California Pan-Ethnic Health Network, says the Council was instrumental in getting California hospitals to gather more data on the languages of those seeing care. A Council task force also devised a plan whereby the state could leverage federal Medicaid dollars to expand interpreter services at health facilities, but California’s budget woes have put that plan on hold. “There is a solid commitment to health equity within the department of public health, but year after year the state’s fiscal crunch threatens good programs.”

California also is home to some of the country’s foremost experts on health equity, and OMH doesn’t hesitate to seek their advice. For example, the Senior Vice President of the California Endowment, Dr. Anthony Iton was featured in the PBS series, "Unnatural Causes: Is Inequality Making Us Sick?"

Other experts include Dr. Paula Braveman, director of the Center on Social Disparities in Health at the University of California-San Francisco. She points to clear progress within CDPH in focusing more on the socio-economic determinants of health. A prime example: Revamping of the Black Infant Health programs to put more emphasis on prevention and the root causes of health problems. “There can be no real progress in health equity unless we addressing the social determinants of health,” says Dr. Braveman, who credits organizations like the California Endowment for helping to sensitize state and local public health leaders to the importance of taking into account a much broader range of factors that influence health.

Looking ahead

Beyond changes in strategy and efforts to build strong partnerships, CDPH leaders emphasize that progress in reducing health disparities depends to a great extent on gathering better data on underserved populations. Hardcastle hosted a 2009 Region IX Data Roundtable, sponsored by the HHS Office of Minority Health, and new approaches on data collection are certain to include “disaggregating” data to get more information on subsets of demographic groups. As an example of the importance of such an approach, Hardcastle points to an OMH poster developed for Multicultural Health Month 2009 that showed new data on the high incidence of infant mortality
among Native Hawaiians/Pacific Islanders. A community group parlayed that information into a generous private grant for new outreach programs for that population.

“Data is still extremely variable across our department, and improving it is a major priority,” says Dr. Horton. “You must have adequate data to determine if there is a disparity or inequity, and that is a complex, multi-year task. We are taking steps in our strategic plan to make sure that all data sets show differential impact on various populations, including coding by racial and ethnic group.”

All these efforts – and more – are part of a state public health agenda that seeks to make headway on health equity, even while resources have been taxed to the limit with budget cuts and costly outreach programs associated with delivering H1N1 immunizations to such a diverse population.

“The best legacy we can leave,” says Dr. Horton, “is transforming our strategy to inculcate the health equity message throughout everything we do.”

For more information on California health equity initiatives:

California Department of Public Health:
http://www.cdph.ca.gov/Pages/default.aspx

Office of Multicultural Health:
http://www.cdph.ca.gov/programs/OMH/Pages/default.aspx

Council on Multicultural Health:
http://www.cdph.ca.gov/services/boards/comh/Pages/default.aspx

Office of Binational Border Health:
http://www.cdph.ca.gov/programs/cobbh/Pages/default.aspx

Los Angeles County Key Indicators of Health 2009:

California Women’s Health 2007:

California State Strategic Growth Council:
http://www.sgc.ca.gov/

California Endowment Center for Healthy Communities:
http://www.calendow.org/cht/

Annie E. Casey Foundation:
http://www.aecf.org/
Center on Social Disparities in Health (Univ. of California, San Francisco)
http://www.familymedicine.medschool.ucsf.edu/csdh/
When Gov. Sonny Perdue appointed Dr. Rhonda Medows to head the Georgia Department of Community Health (DCH) in December 2005, it was clear where she needed to focus her energies. Health disparities among minorities who comprise nearly a third of the state’s nine million people were disturbingly apparent—

- African Americans experienced 44% more premature deaths than did whites.
- Black males were diagnosed with AIDS at a rate of 90.8 per 100,000, compared to 10.3 for whites. African American males were also 39% more likely to die of cancer.
- Hispanics/Latinos were twice as likely to die from heart disease than whites.
- Black females were 13% more likely to die of cancer than white women. And death rates from diabetes were two times higher than for white females.
- Infant mortality rates in the black population were double the rate for whites.

On top of these concerns were high rates of childhood obesity and teen pregnancy among minority populations. What’s more, the state faced an acute shortage of physicians and other medical personnel in its 118 rural counties, where poverty rates exceed that of urban areas by nearly 60%.

**Strategy for Change**

Against this backdrop, Dr. Medows met with top DCH managers shortly after her arrival and stressed that “achieving health equity would become an integral part of our daily operations.” She then moved to revitalize DCH’s 12-member Minority Health Council by appointing prominent leaders from a broad spectrum of health-related fields.

The Council, working with DCH leaders, determined that a key first step was to define the disparity problem in local terms. That launched an intensive research effort leading to the *Health Disparities Report 2008: A County-Level Look at Health Outcomes for Minorities in Georgia.*

This in-depth, 360-page study looked at health outcomes for minorities in all the state’s 159 counties. In a “health report card” section, the document graded each county on the level of equality achieved by minorities versus whites on such factors as mortality, illness events, prenatal care, primary care access, and social and economic indicators (poverty, unemployment, education level). A grade of “A” in any category indicated that minorities had “excellent outcomes with a good to excellent level of equality.” By contrast, an “F” signified “extremely poor outcomes and/or extremely severe racial equality.”

The study gave grades of D or F in the mortality category to 67 counties, in effect pointing out areas where minorities faced the greatest potential for shorter lifespans. Counties receiving an “F” included not only rural areas by urban Fulton County (Atlanta).
“The approach of looking at health outcomes at the local level is essential,” notes Dr. Medows, “because you need to engage communities in building and implementing solutions to these problems.”

With that in mind, DCH in the spring of 2008 launched a series of town hall meetings throughout the state to discuss the report and possible strategies for addressing local health disparities. “We really wanted to go to counties that did not score well in the report to talk to local leadership,” recalls James Peoples, executive director of the DCH Office of Health Improvement (OHI), which spearheads many of the department’s health equity efforts. “These meetings have produced a vast array of responses, but in the end most of the communities were chomping at the bit to move forward and take ownership of the disparity issues.”

Community responses, adds Peoples, have taken several paths. Some wanted DCH to provide more information on health disparities and their impact on health outcomes, as well as ideas on how to get more people involved in solutions, including government officials. Others wanted to know how to get more resources for health equity efforts, which has led OHI to send regular email alerts to about 800 organizations on grant opportunities, services, and educational topics.

In addition, DCH created a Health Equity Grant program, which so far has delivered $1 million in matching funds to community organizations and programs concerned with minority health needs. “It’s a feather in our cap that we aren’t just looking at the data but are getting funding to various programs around the state,” says Katherine Cummings, a member of the DCH Minority Health Council and executive director of the Georgia Rural Health Association.

A Targeted Approach

Besides its ongoing health equity initiative, DCH oversees a number of special programs aimed at some of the state’s most acute disparities. A key example is HIV/AIDS, where Georgia ranks sixth nationally in the number of cases. With funding from the HHS Office of Minority health, OIC operates two programs aimed at curbing and managing the disease. TAKE (Take Action Keep Educated) raises HIV/AIDS awareness and helps public agencies, Hispanic/Latino organizations and faith-based groups coordinate treatment, care and prevention. The other effort -- Project Stronger Together -- builds the capacity of three partner organizations that provide AIDS treatment in the Atlanta area.

Peoples notes that TAKE has enlisted nearly 75% of the HIV/AIDS service organizations throughout the state, which has strengthened collaboration and improved the continuum of treatment and care. Tary Brown, a member of the TAKE Advisory Council, agrees. “TAKE has brought together diverse groups who share ideas and best practices on everything from disease management to issues like AIDS in the workplace,” says Brown, CEO of the Albany Area Primary Health Care Center.

Also aimed particularly at minorities is the ACTS program (Access to Care Treatment and Services), which provides breast cancer screening and treatment for indigent women. Thanks to a special breast cancer auto license tag campaign, the program has allocated $2.7 million since
2006 to organizations and health providers serving low-income families, with another round of funding slated for later in 2010.

Meanwhile, DCH is working to expand health access for underserved populations through rural and migrant worker clinics, critical access hospitals, and programs to alleviate the shortage of health professionals. The Georgia Volunteer Healthcare Program, for example, has enlisted more than 2000 care providers who volunteer their services in their own offices or at 60 free clinics that target uninsured or underinsured individuals and families. Cummings of the Minority Health Council notes that where these clinics exist, they are making a real difference, but she adds that lack of transportation still keeps many rural residents from accessing these services.

DCH publications also reflect the continuing focus on health equity. For instance, the 2008 *Men’s Health Report* not only documented leading causes of death, health behaviors, and access to care for the state’s total male population, but it noted particular problem areas for minorities, such as the high rate of prostate cancer among blacks. Later this year, DCH plans to publish a supplement to the 2008 Health Disparities Report that will provide more information on the state’s Asian population.

**An Expanding Agenda**

With minorities expected to account for an increasing percentage of state population, DCH officials know that they face an uphill battle to reduce health inequality, particularly at a time of scarce resources. Peoples notes that DCH is stepping up its outreach efforts, particularly in the Hispanic and Asian communities, often partnering with community organizations to hold health screenings and education events. That relationship-building mission got a major boost from the state’s aggressive H1N1 education efforts.

Later this year, the department will launch a new round of town hall meetings, many of them designed to assess progress in communities where the first discussions were held on the health disparities report. DCH is also setting up the Georgia Academy for Health Equity, in conjunction with the Morehouse School of Medicine Fellowship Program. Its first priority: Developing a “toolkit” to assist communities in formulating health equity strategic plans.

Dr. Medows sees more opportunities to address health equity in the expanding use of Electronic Health Records. In February, DCH received $13 million from HHS under the American Recovery and Reinvestment Act to create the infrastructure for Georgia’s electronic Health Information Exchange. That comes on top of $3.1 million received in December from the Centers for Medicare and Medicaid Services to create a State Medicaid Health Information Technology Plan.

As Dr. Medows sees it, creation of a robust electronic health records system, which makes a concerted effort to include patient data from providers who treat minority populations, will provide valuable information for clinical research, healthcare planning, and targeted programs for at-risk populations. “Once this electronic system is set up,” explains Dr. Medows, “you’ll be able to pull up such data as the number of men who have prostate cancer, based on a racial or ethnic demographic.”
Meanwhile, DCH regularly consults with its Minority Health Council to chart future plans, including implementation of a Quality Strategic Plan. Among other things, this plan requires such entities as the State Employee Health Plan, Medicaid, and SCHIP (State Children’s Health Insurance Plan) to assess their progress in reducing health disparities, such as high infant mortality in the black population. Says Dr. Meadows: “To make progress in health equity, it’s got to be an integrated, department-wide effort.”

**For more information on Georgia’s health equity initiatives:**

Georgia Department of Community Health (DCH)
[http://dch.georgia.gov/02/dch/home/0,2467,31446711,00.html](http://dch.georgia.gov/02/dch/home/0,2467,31446711,00.html)

DCH Office of Health Improvement
[http://dch.georgia.gov/00/channel_title/0,2094,31446711_35901970,00.html](http://dch.georgia.gov/00/channel_title/0,2094,31446711_35901970,00.html)

DCH Office of Minority Health
[http://dch.georgia.gov/00/channel_title/0,2094,31446711_40827916,00.html](http://dch.georgia.gov/00/channel_title/0,2094,31446711_40827916,00.html)

Minority Health Advisory Council
[http://dch.georgia.gov/00/channel_title/0,2094,31446711_40827916,00.html](http://dch.georgia.gov/00/channel_title/0,2094,31446711_40827916,00.html)

Georgia Health Equity Initiative
[http://dch.georgia.gov/00/channel_title/0,2094,31446711_40829902,00.html](http://dch.georgia.gov/00/channel_title/0,2094,31446711_40829902,00.html)

Georgia Health Disparities 2008 Report

DCH Men’s Health Report 2009

Georgia HealthInfo.Gov
Even in a state that has shown leadership in many areas – perhaps most notably the 2006 legislation requiring near universal health insurance – health care leaders admit that much more needs to be done.

“As you dig deeper into racial, ethnic, and linguistic populations, you find so often that we are just scratching the surface,” says Georgia Simpson May, director of the Office of Health Equity in the Massachusetts Department of Public Health (MDPH). “For example, what must be done to help disabled people within these populations?”

Over the last five years, Massachusetts has indeed shown a willingness to “dig deeper” with a strategy that includes greater representation for minorities in health-care leadership, a broad-based council targeting health disparities, funding of innovative grants, and widespread implementation of national Culturally and Linguistically Appropriate Services (CLAS) Standards.

Even so, at a time when MDPH has had to cut $80 million from its budget and eliminate 300 positions, Commissioner John Auerbach notes that the remaining challenges surrounding health disparities are enormous. “But we must not only continue this work in health equity but try to expand it, even doing tough economic times, because it is too high a priority to neglect.”

Agents for change

Much can be accomplished, notes Auerbach, by adopting a broader definition of public health beyond delivering services. When he became public health commissioner in 2007, Auerbach established the Office of Health Equity – formerly the Office of Multicultural Health – within the commissioner’s office. And he has directed the department’s 10 bureaus to address the health equity issue as an ongoing concern in their programs. At the same time, he reached out to other state departments, such as education, transportation, housing, and the corrections system, with a message to consider their role in attacking the social determinants that can lead to poor health.

Within his own department, the commissioner changed the makeup of his top staff from a situation where all 20 senior managers were white to where minorities now make up more than 25% of that management staff. Dollars spent on health promotion campaigns, such as the new “Mass in Motion” program to fight obesity, also are focusing to a greater extent on minority populations. Similarly, cities and towns competing for grants encouraging farmer’s markets and other new food outlets get added consideration if they target “food deserts” areas in their communities.

MHDH is also working closely with the new Health Disparities Council (HDC) created in 2006 as part of the state’s groundbreaking Health Care Reform Law. The 37-member council includes
key state public health leaders, state legislators, and representatives from medical centers, local health departments, insurance companies, public health associations, and universities.

Already, HDC, which is staffed by the MDPH’s Executive Office of Health and Human Services, has developed a framework for planning, implementing, and evaluating programs along six objective areas, including:

- Adopting social policies that increase equity, such as environmental, economic, and education programs that benefit socially disadvantaged communities.
- Promoting healthy communities through policies that encourage safer streets, greater access to healthy food, and more physical activity.
- Encouraging the transformation of institutions, such as companies and treatment centers, for greater sensitivity to health equity.
- Promoting the transformation of health care providers, including expanding the number of health professionals from minority and ethnic groups.
- Promoting healthy individual behavior through initiatives that encourage health lifestyles, expand access to preventative care, and treat chronic disease.

Miriam Messenger, who directs grant policy at the Blue Cross/Blue Shield Foundation of Massachusetts, says her organization has begun to share information on its grant programs with HDC and is also taking suggestions from the council both for future grants and for research projects. “If we launch a project studying cost containment, for example, we want to be sure that we address the implications for reducing health disparities,” explains Messenger. About 30% of the foundation’s annual grants underwrite programs involved with health equity issues, such as improving the linguistic and cultural competence of care givers.

In June of 2010, the HDC plans to complete its first health “report card” for Massachusetts, zeroing in on the progress the state is making on such key health issues as obesity and chronic diseases like diabetes. The report will go beyond disease management issues to assess efforts to get at the social determinants of health problems.

Another priority for HDC is adopting a set of standards for medical interpretation, an area where Massachusetts has already established national leadership with 24/7 interpreter services for individuals seeking care at hospital emergency rooms. Among other things, HDC will be making recommendations on a certification process for interpreters, as well as for reimbursement for interpreter fees. In addition, a new working group of HDC will be monitoring state legislation for possible impact on health disparities.

**Best in CLAS**

The Office of Health Equity is also driving the MDPH’s CLAS initiatives, under a five-year federal HHS grant. Agencies and vendors that apply for grants and contracts with MDPH now have to rate themselves, using a five-point scale, on eight different components of the CLAS standards, such as recruiting and training policies, as well as their record in collecting data on race, ethnicity and language in their service area. They also need to provide information on the racial makeup of staff and their multi-lingual capability.
Meanwhile, eight different CLAS initiative committees representing a wide variety of staff functions within MDPH’s bureaus are developing tools to make CLAS standards viable within MDPH, in other state agencies, and in communities. A procurement committee, for example, assists grant applicants with assessment tools and CLAS language for funding applications. Another committee developed a “Making CLAS Happen” manual, released in June of 2009, with detailed information on how hospitals and other entities can implement CLAS. And on the web, interested parties can view a training session on “CLAS 101.”

Finally, an internal assessment committee in January will unveil a quality assurance program for evaluating how MDPH is operating with respect to observing CLAS. “We’re talking about practices such as having properly translated materials for the public, or having phone line access with multiple languages,” explains May.

**Quest for innovation**

As a springboard for assessing future health equity priorities, the state’s public health leaders cite the importance of the 2007 “Race and Ethnicity Report,” a 354-page document giving detailed health status information by region. The report summary noted that “Massachusetts has the best performance of any state in the nation for many health indicators. Yet when we examine the diverse groups that make up the state’s population, we find that there are those whose health is far worse than that of the state as a whole.”

In addition to ongoing data collection, MDPH also hopes to learn more about what really works in health equity by assessing 35 three-year “health disparity” grants awarded in 2007. The grants run the gamut from workforce development projects, such as a program to encourage aspiring nurses in the Latino community, to a medical-legal partnership pilot to help families suffering from asthma related to substandard housing. “We view these local programs as Petri dishes that we can expand to other areas if they can demonstrate success,” says May.

Commissioner Auerbach admits that the tough economy makes it very difficult to expand new health equity programs, yet he points to the need to try new ideas, such as employing more community health workers who focus on the broad factors contributing to poor health in underserved communities. “The problems surrounding health disparities are so large that some people are simply reluctant to take them on,” says Auerbach. “But we resist that thinking. We need to do anything we can, no matter how small it may seem.”

**For more information on Massachusetts’ health equity initiatives:**

Massachusetts Department of Public Health:
[http://www.mass.gov/?pageID=ehohs2agencylanding&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=Department+of+Public+Health&sid=Eehohs2](http://www.mass.gov/?pageID=ehohs2agencylanding&L=4&L0=Home&L1=Government&L2=Departments+and+Divisions&L3=Department+of+Public+Health&sid=Eehohs2)

Office of Health Equity:
[http://www.mass.gov/?pageID=ehohs2terminal&L=5&L0=Home&L1=Government&L2=Depart](http://www.mass.gov/?pageID=ehohs2terminal&L=5&L0=Home&L1=Government&L2=Depart)


Health Disparities Council: http://www.mass.gov/hdc/

Michigan: Staying the Course

When your state suffers the highest jobless rate in the nation and your budget has been slashed virtually every year since 2003, making progress on health equity might almost be described as mission impossible.

Yet that is precisely the challenge that the Michigan Department of Community Health (MDCH) faces as it seeks to carry out a legislative mandate to reduce health disparities at a time of scarce resources.

“We cannot improve the health of Michigan citizens without a strong focus on equity,” says Janet Olszewski, MDCH director. “People of color in our state fare even worse during this economic downturn, and that exacerbates their health issues.”

Yet even while the economy has slumped, MDCH over the last four years has managed to launch several new initiatives, including major conferences on health disparities, annual reports to the legislature outlining initiatives that help the underserved, and new grants to build the capacity of communities for health equity-related activities.

“MDCH has really done an amazing job in keeping health equity as a priority, even though its resources have been shrinking,” notes Karen Holcomb-Merrill, a public policy expert at the Michigan League of Human Resources. The league has been urging the Michigan legislature to increase revenues, rather than continue budget cuts that have hurt key programs, including those aimed at preventing the extremely high rates of infant mortality among African Americans.

**Leading the Way**

Like many states, Michigan established an Office of Minority Health many years ago – 1988 – but the state refocused its efforts in 2006 when the office became the Health Disparities Reduction and Minority Health (HDRMH) section within the Division of Health, Wellness and Disease Control. Through analysis of racial and ethnic data, including the US Healthy People and Healthy Michigan 2010 goals, the new HDRMH targeted five populations: African Americans, Hispanics/Latinos, Native Americans/Alaskan Natives, Asian Americans/Pacific Islanders, and Arab-Americans. These populations were not only growing faster than the state’s white population, but were suffering disproportionately high rates of cardiovascular disease, diabetes, cancer, HIV/AIDS, infant mortality, and injuries related to violence.

With this underserved population in mind, HDRMH leads the department’s health equity efforts by shaping overall strategy for reducing disparities, improving race/ethnicity data collection, documenting effective programs, and building partnerships with local health departments and community groups.
“We’re a small staff,” says Sheryl Weir, MPH, manager of the HDRMH section. “So we must put the emphasis on education, technical assistance, and leveraging the resources of our partners in communities.”

“In data collection, for example, community organizations can be a valuable ally to MDCH in getting more detailed information on racial and ethnic groups”, says Weir. That’s particularly important for smaller racial/ethnic populations. She notes that the Michigan Intertribal Council used its own resources to conduct a Behavioral Risk Factor Survey on American Indians residing in the state. Similarly, the Arab Community Center for Economic and Social Services (ACCESS) did a health survey of Michigan’s Arab American population, which it estimates to be about 300,000, one of the largest in the U.S.

HDRMH is also shifting its focus from targeted programs residing within MDCH to helping local organizations identify and address disparity issues most important to them. This year, for example, the section is coordinating a new program that channels $365,000 in capacity-building grants to local organizations serving the five targeted populations. Money comes from CDC Prevention Block Grants and the state’s Healthy Michigan Fund, based largely on tobacco taxes. As part of the capacity building program, HDRMH is providing extensive training on health equity issues for leaders of organizations receiving the grants.

One of the new grants was awarded to the Joy-Southfield Community Development Corporation, which runs a free health clinic, as well as economic initiatives like home repair and foreclosure prevention assistance. Joy-Southfield’s capacity-building grant will target issues related to childhood obesity, says Executive Director David Law, and will include such elements as a new farmer’s market, greater supplies of fresh fruits and vegetables in area stores, exercise programs, and safe walking routes to schools. The nonprofit agency will partner with Blue Cross/Blue Shield of Michigan for additional funding.

“MDCH has been a very valuable partner for us and has done a remarkable job in health equality despite funding cuts,” says Law, whose clinic records about 5000 visits a year from a predominantly black clientele.

**A Matter of Accountability**

Though the legislature in recent years has not raised revenues to prevent cuts in MDCH’s health equity efforts, the department nevertheless is required by 2006 Minority Health legislation to report each year on its progress in reducing health disparities.

In the recently released 2009 Health Disparities Report, MDCH identified 50 different programs related to health disparities, serving more than two million clients. Programs range from asthma case management and birth defect follow-up to prevention efforts against HIV/AIDS, sexually-transmitted diseases, and hypertension.

“I view this report very positively,” says Director Olszewski. “It serves as a public podium for the health equity issue.”
One highlighted program in the 2009 report featured a Cardiovascular Tool Kit that was disseminated to more than 150 churches, most of them African-American congregations. Another effort that has enjoyed considerable success, notes Director Olszewski, is the “Check Up or Check Out” program. It uses education and community outreach to encourage black males, a group suffering the worst health outcomes, to develop an ongoing relationship with a primary care physician. David Law of Joy-Southfield says the program has contributed to a significant increase in the number of black males visiting his clinic over the last two years.

Yet despite such efforts, the 2009 report revealed a disturbing picture of the disparities that still exist in the state. For example:

- The infant mortality rate among blacks was nearly triple that of whites.
- African Americans made up 14% of the state’s population but accounted for 60% of new HIV/AIDS cases.
- An estimated 16.5% of American Indians had diabetes, versus 7.3% for whites.
- The cancer mortality rate per 100,000 population stood at 230.5 for blacks, compared to 181.4 for whites.
- The homicide rate: 31.9 for blacks, 5.9 for Hispanics, and 2.3 for whites.

To dig deeper into the root causes of such disparities, Weir plans to incorporate in future reports to the legislature a new Michigan Health Equity Data Set, which will include information on education, income, employment, residential patterns, and other socioeconomic indicators. “If you want to get at the “why” behind inequity in health, you need to do comparisons on the social determinants of health,” says Weir, who hopes to gather such data in three to five-year increments to chart the progress.

**The Road Ahead**

An important ally in helping HDRMH develop health equity strategy is the MDCH Health Disparities Working Group, with representatives from throughout the department. The group focuses on such issues as employee training in social justice and CLAS standards (HHS Culturally and Linguistically Appropriate Services). In addition, group members reviewed applications for the new capacity-building grants and will provide technical assistance as needed to grant recipients.

The Working Group will also assist HDRMH in creating a new Health Equity Roadmap that will provide direction for future department priorities. In shaping that report, MDCH will draw from ideas voiced at annual health disparities “summits” that began in 2008. These conferences have brought together a wide range of stakeholders, including national experts, MDCH staff, local health departments, community and faith based groups, academics and researchers.

The first two conferences focused on raising awareness on health disparities and soliciting views from diverse audiences. This year’s conference, says Weir, will emphasize model programs that community organizations can emulate.
Last year, too, HDRMH sponsored 22 “community conversations,” hosted by local organizations and public health agencies, to discuss key concerns and conditions affecting health throughout the state. Those sessions involved all the key racial and ethnic groups served by MDCH in its health equity efforts.

Still, while such consensus-building steps are important, health experts in Michigan stress that an improving economy, along with increased funding, are essential if hard-hit Michigan is to make real progress in closing health disparities gaps. In her paper on the impact of state budget cuts on MDCH programs, Holcomb-Merrill of the Michigan League of Human Services writes: “Cuts to disparity reduction initiatives are very short-sighted. While they may save money in the short run, they will cost money in the long run, and they will cost lives, including the lives of the most vulnerable.”

MDCH Director Olszewski sees a clear ray of hope from the new federal health reform legislation. “It’s going to help us a great deal,” she says. “More of the uninsured will now be covered, preventative care and immunizations won’t require co-pays, and we may be able to tap a new prevention and wellness fund for programming dollars. It’s going to take some time to develop, but health reform is clearly a victory for health equity.”

For more information on Michigan’s health equity initiatives:

Michigan Department of Community Health (MDCH)
http://www.michigan.gov/mdch

MDCH Health Disparities Reduction and Minority Health Section
http://www.michigan.gov/mdch/0,1607,7-132-2940_2955_2985-16949--,00.html

MDCH 2010 Capacity Building Grants Program

MDCH 2009 Health Disparities Report to the Legislature

MDCH 2008 Profile of Michigan Racial and Ethnic Populations

MDCH Strategic Plan 2009-2011

Intertribal Council of Michigan Behavioral Risk Factors Survey

Michigan League for Human Services: Looming Cuts in Michigan’s Budget
Threaten to Widen the Gulf in Health Disparities
Montana: Outreach to Native Americans

There’s no mystery about where Montana must direct its campaign to reduce health disparities. Of the state’s nearly one million residents, about 7% are Native Americans – by far the largest minority population and one that has had significant economic challenges for decades.

In Glacier County, which includes the Blackfeet reservation, one in every four persons lives in poverty, and the jobless rate on the reservation itself approaches 70%. It’s much the same story in Big Horn, Blaine and Roosevelt counties, also home to large tribal populations.

Against that backdrop, health outcomes for Native Americans in Montana seriously lag those of white residents. A report on prevention opportunities from the Montana Department of Public Health and Human Services (DPHHS) shows that in the 1990 to 2003 period American Indians had an excess death rate of 58% versus whites. Death rate exceeded that of whites by 23% for stroke, 29% for heart disease, 40% for chronic lower respiratory disease, 42% for cancer, 227% for motor vehicle injuries and 291% for diabetes.

Meanwhile, the federal Indian Health Service (IHS), which provides much of the medical care on reservations and at urban Indian centers, remains vastly underfunded. “The country spends more each year per capita on health care for prisoners than it does for Native Americans,” says Kathie Avis, who administers programs for Native Americans at Benefis Health Systems, which serves 13 Montana counties, including three reservations.

Accent on prevention

Reducing those disparities is a daunting challenge for DPHHS. With their status as sovereign nations, Montana’s Indian reservations have traditionally wanted to deal directly with the federal government on everything from health care to economic development. But Anna Whiting Sorrell, appointed in 2008 by Governor Brian Schweitzer to head DPHHS, wants to make sure her department plays a key role in health issues pertaining to Native Americans. “The tribes want the relationship to be with the federal government,” she says, “but we know that most federal money goes directly to the states to run programs like Medicaid and CHIP (Children’s Health Insurance Plan). So you can’t leave us out of the conversation.”

Whiting Sorrell speaks from experience. An enrolled member of the Confederated Salish and Kootenai Tribes, she makes her home on the Flathead Reservation in Ronan and has spent much of her career working on tribal self-governance and legislative issues. She also developed a nationally recognized substance abuse prevention and treatment program for the tribes.

To ensure that sensitivity to Native American health issues is part of the core business of DPHHS, Whiting Sorrell cites the importance of a new Tribal Work Group, which brings together key personnel throughout her department. The group provides guidance and training on
strategies for working with the tribes and maintains a calendar of important health-related events taking place on reservations and urban Indian centers.

Within DPHHS, several programs administered by the Chronic Disease Prevention and Health Promotion Bureau serve a large percentage of Native American clients, notes Bureau Chief Todd Harwell. “Most of our funding comes from CDC,” says Harwell, “which requires that we identify disparities and develop strategies to address them. In Montana, those disparities essentially involve Native Americans, rural residents with limited access to health care, and the poor in urban communities.”

One effort that has enjoyed particular success is the Breast and Cervical Health Program. Aimed at lower-income women, the program enlisted the American Indian Women’s Health Coalition to promote cancer screening in remote tribal locations. Result: Annual screenings have increased nearly tenfold since 2000. Says Harwell: “Our cancer control staff really worked hard not only to identify local women to help with outreach but also to establish links with IHS and with local clinics, including those operated by the tribes.”

Involving Native Americans is critical to program success, says Kathie Avis of Benefis Health System, which runs a Native American Cancer Disparities project. Each of the more than 1300 persons enrolled in the program have a Native American “navigator” who monitors them for proper cancer screening. “This helps us overcome cultural obstacles, such as fear of testing, which traditionally caused people to avoid screening until cancer reached an advanced stage,” says Avis. As a result, screening for participants has jumped from less than 10% to 60% in three years.

Another major prevention focus is tobacco use. An annual tobacco survey administered by DPHHS finds that nearly 40% of adult Native Americans in Montana smoke, versus about 17% for white adults. As a consequence, the incidence of lung cancer is 47% higher among Native Americans, according to a 2009 Cancer in Montana report. The state’s Tobacco Use Prevention Program includes special messages to discourage young people from smoking or using “spit tobacco,” a “quit line” that provides counseling, and free or sharply discounted cessation drugs like Chantix.

The tribes and urban Indian centers received nearly $884,000 from the state during fiscal 2009 to implement the tobacco control program and to develop culturally appropriate messages. Yet serious challenges remain. Montana’s new Clean Indoor Air Act prohibits smoking in bars, restaurants, casinos, offices and other public places. However, the statute does not apply to Indian Reservations, which must decide whether to follow the state’s lead in clamping down on the health dangers of second-hand smoke.

Alliances that work

Other health equity initiatives combine DPHHS resources with those of other departments. A prime example is a new injury prevention program, involving DPHHS, the Department of Transportation, the Billings area IHS, and tribal workgroups. Of particular concern: National
Highway Traffic Safety Administration figures showing that Montana leads the nation in alcohol-impaired fatality rates in auto accidents.

“Instead of duplicating efforts,” says Bureau Chief Harwell, “we wanted to find ways so support measures that that tribal workgroups were already undertaking in injury prevention, such as promoting the use of seatbelts and child safety seats.”

Vicki Turner, director of the DPHHS Prevention Resource Center, adds that the relationships established in the injury prevention program helped lay the groundwork for a recently launched interagency program called SBIRT (screening, brief intervention, referral to treatment). Here, health professionals, such as emergency room personnel, are trained to spot signs of alcohol abuse in patients who are seeking treatment for an injury. “The goal is to have these health professionals refer such patients to alcohol counseling and treatment,” says Turner, who adds that four major urban Indian centers are helping to implement the program.

Alcohol abuse, particularly underage drinking and DUI, also have become the primary target for the state’s Interagency Coordinating Council, which harnesses the resources of several departments, including: DPHHS, Attorney General’s Office, Public Instruction, Indian Affairs, Labor and Transportation. Action steps include a new Web site for parents on underage drinking and collaboration with law enforcement and judges on such measures as ignition locks and ordinances that hold adults liable for hosting drinking parties for minors.

**Leveraging resources**

Such programs are tough to maintain at a time when state government is stretched to the breaking point from a struggling economy. Citing a successful visiting nurse program to counsel low-income expectant mothers and discourage alcohol use, health promotion administrator Dorothy Bradshaw of the Lewis and Clark County Health Department notes that “the state has had to work hard to find the money to keep the program going.” She also gives DPHHS high marks for reaching out to struggling families in remote areas with programs like WIC, and she urges more use of telemedicine in areas where face-to-face health care is difficult.

To help stretch resources, DPHHS has made aggressive use of such federal programs as VISTA, which funded 30 volunteers in 2009 to work in several community outreach activities, including: suicide prevention and tobacco control, data collection, and enrolling families in CHIP. “Montana has a higher percentage of VISTA volunteers, based on population, than does California,” says Turner of the Prevention Resource Center.

Consistent with the growing national focus on the social determinants of health, the Schweitzer administration has also put heavy emphasis on diversity and cross-cultural participation across a broad range of state programs that directly or indirectly affect health. Besides Whiting Sorrell, Schweitzer has named Native Americans to several prominent posts, including: Jennifer Perez Cole, director of Indian Affairs and Lesa Evers, Governor’s Indian Country Economic Development Advisor. In all, he has appointed more than 120 American Indians to cabinet positions, state boards, and commissions – a number that Schweitzer says surpasses the commitment of any previous administration.
The Governor’s 2009 Tribal Relations Report details all these appointments and describes progress in a raft of state-administered programs to improve the lives of Native Americans in areas ranging from health and education to infrastructure and economic development.

Because of what she sees as the governor’s strong commitment to diversity, Whiting Sorrell doesn’t see the need for a separate office dedicated to addressing health disparities. “I believe in integration, not segregation,” she says. “Native American issues, Hispanic and black issues, gay and lesbian issues – these should be part of the everyday fabric of what we do in state government.”

**For more information on Montana’s health equity initiatives:**

Montana Department of Public Health and Human Services:

Montana DPHHS Fiscal 2011 Goals and Objectives:

Advisory Boards and Councils to Montana DPHHS

Montana County Health Profiles

Major Prevention Opportunities to Improve Health in Montana

Cancer Among American Indian Residents of Montana, 2003-2007

Montana Tobacco Use Prevention Program
http://tobacofree.mt.gov/

Tribal Relations Report 2009
In North Carolina, a state with a long history of programs to reduce health disparities, healthcare leaders recognize two glaring realities: Progress comes slowly, and it doesn’t happen at all without strong local participation.

“North Carolina has consistently ranked in the 35th to 40th position in health status among the states over the last 20 years,” observes Jeffrey Engel, MD, State Health Director for the state’s Department of Health and Human Services (DHHS), “and the primary reason is the health disparities that still exist. Yes, we have managed to close the gap in such areas as infant mortality, but the rate for blacks is still more than twice that for whites.”

With limited state government funds, Engel stresses the importance of empowering other entities, ranging from universities and local health departments to community and faith-based groups, to wage their own campaigns against disparities. “The state role is to provide strategic direction, technical assistance and quality assurance,” explains Dr. Engel. “We can’t be the primary funder.”

**Catalyst for Action**

Engel says the state’s most valuable tool in addressing health inequity is its Office of Minority Health and Health Disparities (OMHHD), established by the North Carolina General Assembly in 1992. Under the direction of Barbara Pullen-Smith, MPH, the office serves as the catalyst for keeping the disparities issue a priority within DHHS, as well as for building the capacity of local groups to operate programs aimed at the most serious health problems affecting minorities.

Within DHHS, Pullen-Smith’s office works closely with an Eliminating Health Disparities Steering Committee that includes representatives from 12 divisions within DHHS. The committee meets monthly to discuss issues affecting disparities throughout DHHS, and every six months each division representative files a report to OMHHD on the progress that his or her division has made on its own health disparities reduction plan. These plans are based on nine recommendations set forth in a 2003 DHHS report, “Eliminating Health Disparities Call to Action.” Finally, committee members meet annually with the DHHS secretary to review both accomplishments and challenges in their plans.

The steering committee is also a valuable conduit to DHHS resources that OMHHD needs to support local health disparity efforts. “If we need to pull together a basic awareness program on HIV/AIDS, steering committee members can recommend subject matter specialists,” explains Pullen-Smith.

In addition, committee members have worked with OMHHD to develop a new web-based training program on cultural competency that will be available this year to all 19,000 DHHS employees. “While many divisions offered such programs in the past to small groups, the
steering committee agreed that we needed to reach far more staff in a timely manner,” says Pullen-Smith.

**Partnering with the Grassroots**

Beyond such internal DHHS efforts, OMHHD uses its own staff of health consultants to build relationships with community and faith-based groups, as well as to train them to administer their own health disparities programs. In that effort, the office has a powerful ally in the Minority Health Advisory Council (MHAC), also established in 1992 by the General Assembly. The 15-member council includes legislators, community leaders, and healthcare providers, appointed by the Governor, Speaker of the House, and President Pro Tempore of the Senate.

Each quarter, the MHAC meets with OMHHD to review priorities, set strategies and identify obstacles to progress in health equity. “We also look at best practices in other states and often invite representatives of community groups to discuss problems they’re facing,” says state Rep. Beverly Earle, the current MHAC chair. “I’m a big believer in letting people at the grass roots identify their concerns, rather than having outsiders come in with the answers.”

The MHAC, with strong backing from the minority caucus in the General Assembly, has successfully pushed for major legislation in recent years on health disparities, tobacco control, heart disease and stroke prevention, infant mortality, obesity prevention, and interpreter services for local health departments.

One of the biggest legislative victories has been a major multi-year grant program called the Community Focused Eliminating Health Disparities Initiative (CFEHDI). Starting in 2005, CFEHDI has supported prevention programs administered by faith-based and community organizations, local health departments, and American Indian Tribes. Funds have grown from $1 million annually to nearly $2.9 million for this year’s 35 grantees. The grants, which this fiscal year support 23 full-time and 156 part-time community health workers, focus on the most severe health disparities: HIV/AIDS, cancer, diabetes, infant mortality, homicides, and motor-vehicle deaths.

Leaders of organizations receiving grants are required to take health disparities training, develop a volunteer network, demonstrate good fiscal management, and file reports on their activities to OMHHD. “Our philosophy has been to invest in the people who are experiencing the disparities,” says Pullen-Smith. “The goal is to help grantees gain the capacity and expertise to be sustainable operations, capable of raising funds, establishing partnerships with other agencies, and applying for government grants on their own.”

A prime example of such an organization, says Pullen-Smith, is the Cape Fear Regional Bureau for Community Action. Founded in 1989, the bureau has supplemented its state grants with additional monies from Cumberland County, as well as donations from businesses and faith groups. “As a non-traditional, community-based organization, we feel a gap that is not being addressed by local public health departments,” says director Ashley Rozier. “Our staff is available seven days a week, and we go into the jails and storefronts to provide AIDS tests,
cancer screening, diabetes counseling – whatever is needed, including food, transportation and clothing”

Besides its capacity-building grants, OMHHD has spearheaded efforts to build a network of lay health advisors throughout the state who work with community groups and agencies, as well as help people navigate the healthcare system. The Community Health Ambassador Program, started in 2006, has enlisted community colleges to provide a 22-hour training module on diabetes prevention and management to 250 community leaders. A new module is being planned on heart disease. Another program -- the Community Empowerment Network – partners with North Carolina A&T State University for leadership training of clergy. The goal: Prepare the pastors to address disparities in education, health, and the economy in their communities. So far, this effort has reached leaders of some 150 congregations in 19 counties.

Says Pullen Smith: “With these two programs, we are building a network of informed health leaders who are raising awareness about disparities and working to prevent them. But these same leaders can be mobilized to help people in the community understand such issues as the new healthcare reform legislation.”

Assessing Progress

What impact are these and other DHHS efforts making on health disparities? One measure of progress has been the Racial and Ethnic Disparities Report Card, pioneered in 2003 by OMHHD and the State Center for Health Statistics. The document compares the status of four minority groups – African Americans, American Indians, Asian/Pacific Islanders, and Hispanic/Latinos – against that of the state’s white population, using a comprehensive series of health and socio-economic indicators.

Letter grades are assigned for each indicator, such as heart-disease deaths per 100,000 population, or percentage of adults with no health insurance. A ratio of 1.0 in any measure signifies that no disparity exists, which merits an “A” grade. By contrast, a ratio of 2.0 to 2.9 demonstrates a serious disparity and merits a “D” grade. In the 2006 report card, for example, a “D” grade was indicated for blacks and American Indians in diabetes deaths per 100,000 versus whites. The high ratio of AIDS deaths among blacks merited an “F.”

Report card results, says Pullen-Smith, help her office set priorities. High rates of minority-population deaths from AIDS, cancer, and diabetes in the 2006 report were a key factor in deciding which community-based programs received grants under CFEHDI.

OMHHD is issuing an updated report card this year, which will expand the number of indicators from 37 in 2006 to 44, including new measures on home ownership and school dropout rates. While the indicators show state-wide statistics, data is also available for major counties. GIS (geographic information system) software is also being used in some counties to drill down to the census tract level.

Pullen-Smith notes that community-based programs to eliminate disparities can’t be expected to significantly impact health statistics at the state or even county level. “But,” she adds, “there’s no
question that these programs do have an impact on the populations they serve. We see the figures on doctor visits, cancer screenings, and other prevention steps that they are saving lives.”

State Health Director Engel also is encouraged by new partnerships that are being formed to help close the disparity gap. For instance, Duke Medicine, the umbrella organization for Duke University’s health system, medical school and nursing school, now operates Durham Regional Medical Center, whose patient base includes a large minority population. Facilities include free clinics and a federally-qualified health center.

“Duke Medicine is now heavily involved in local community health in Durham County, working closely with stakeholders in that area, including the local health department, and it’s getting the job done with very little state money,” notes Dr. Engel. “We need to encourage such models across the state.”

**For more information on North Carolina’s health equity initiatives:**

North Carolina Department of Health and Human Services (DHHS)
[http://www.dhhs.state.nc.us/](http://www.dhhs.state.nc.us/)

North Carolina Public Health (NCPH)

North Carolina Office of Minority Health and Health Disparities (OMHHD)
[http://www.ncminorityhealth.org/omhhd/](http://www.ncminorityhealth.org/omhhd/)

NC Community Focused Eliminating Health Disparities Initiative

DHHS Eliminating Health Disparities Call to Action (2003)


Minority Health Advisory Council
[http://www.ncminorityhealth.org/omhhd/OMH_AboutUs/OMHMHACPage.htm](http://www.ncminorityhealth.org/omhhd/OMH_AboutUs/OMHMHACPage.htm)
Ohio’s Department of Health (ODH), like departments in other states, has launched targeted programs to reach underserved populations. An Infant Mortality Reduction Initiative, for example, works with health care providers to educate African-American mothers about prenatal and well-baby practices. Other programs, like the Community Heart Health program and the newly launched Obesity Prevention plan, seek to change behaviors that lead to chronic diseases in minority communities.

But as important as these programs are, health care leaders in Ohio stress that it is even more vital for the state to build a lasting infrastructure to ensure health equity. “We need to have a 360-degree understanding of health equity,” notes Chip Allen, the Health Equities Coordinator for ODH. “That means not just treating the aftermath of health disparities, such as high infant mortality or chronic diseases like diabetes, but addressing the social determinants that caused those problems in the first place.”

For ODH, that thinking translates into putting Health Equity front and center in its leadership focus and strategic planning. Governor Ted Strickland, elected in 2006, made health care a major issue in his campaign and established the Healthy Ohio program within ODH. Healthy Ohio -- “the State of Living Well” -- in turn supports three core tenets: health equity, health promotion, and disease prevention.

A matter of strategy

ODH’s new strategic plan for 2009-2011 reinforces Healthy Ohio’s goal of “reducing health disparities in access, quality and outcomes among vulnerable populations through targeted prevention and care coordination programs.” This strategic roadmap establishes health equity as a “cross cutting priority” throughout ODH’s organization and programs.

In practical terms, perhaps the biggest impact of this new strategy affects its policies surrounding the grants it makes to some 130 local health departments and other agencies. Beginning in April of 2009, all grant applications must contain language describing how the program will help reduce health disparities.

That’s a major departure, and Health Equity Coordinator Allen admits that there’s been some pushback. “This new grant policy represents a major change and a level of accountability that people haven’t been used to,” he says.

To ease the transition, Allen has developed a seven-module training program for state and local health departments and community agencies that explains the new grant focus on health equity and what applicants need to do in order to be competitive. Designed as interactive webinars, these sessions are held in conjunction with the state’s five local offices of minority health and provide key technical assistance.
Office of Healthy Ohio, like the other branches of ODH, is increasingly relying on such web approaches for health promotion, education, and training. In the Healthy Lifestyles section, for example, click on categories like “Nutrition” or “Physical Activity,” and you get a wealth of tools, tips, and web links to more information. Using the Microsoft Live Conference tool, Allen expects to use the web increasingly for health-equity related webinars, where he will turn control of the session over to participants. “Unless you harness new technology, you don’t have a chance of getting ahead of the curve,” adds Allen.

**Getting to the numbers**

Effective health equity programs also depend on collecting hard data that measure not only the prevalence of disease but also the social and economic causes that lead to illness. Accordingly, the Office of Healthy Ohio has developed extensive community profiles on all 88 counties. The 2008 profile on Cuyahoga County (metro Cleveland) alone runs 24 pages and includes such data as demographics, socioeconomic status, access to health care, leading causes of death, risk factors and much more. The profiles are intended to enhance health care planning both at the state and local level.

In addition, ODH has increasingly turned to the Nielsen Claritas software tool to drill down to the local census tract level to study health disparities and behavior that can lead to disease. “With this tool, we can tell you how much the average family spends on cigarettes versus fresh fruit and vegetables,” says Allen.

New web-based software programs also promise to yield much more detailed information on the state of local programs funded by ODH. Alvin Jackson, MD, the ODH director, is pressing hard for widespread deployment of a new web-based project management software called the “Subgrantee Performance Evaluation System,” which requires grant recipients to file regular online progress reports on programs. “Once this system is installed, ODH staff should know much faster if a program at the local level isn’t working as it should,” explains Allen, who admits that it has often been difficult to know when targeted programs are “moving the needle” in terms of closing disparity gaps.

**Forging partnerships**

With limited funds to increase internal staff and other resources dedicated to health equity, ODH also understands the importance of leveraging other entities throughout state and local government in the campaign to reduce health disparities – including departments that on the surface aren’t responsible for health care, such as transportation, police, or economic development.

Also essential: building partnerships with a whole host of organizations around the state. The Ohio Commission on Minority Health, an autonomous state agency that was once a part of ODH, works closely with the department on many fronts. Its Research and Evaluation Enhancement Program (REEP) has created an ethnic/cultural research agenda, as well as evaluation system for assessing the outcomes of commission-funded programs to alleviate health disparities.
Also very significant, says Commission Executive Director Cheryl Boyce, are the joint development grants that the ODH and the commission have funded to support community-based programs, some of which have evolved into independent nonprofit organizations. Among the examples: Toledo’s Adelante, Inc., which began as a drug abuse program and now is a broad-based agency that tackles issues ranging from financial education to health care and domestic violence.

“Too often, programs die when the funding goes away,” explains Boyce. “For real progress, we need to build a health care infrastructure that includes not only service programs, but legislation, policy and funding.”

ODH allies like the Commission on Minority Health and the Ohio Chapter of the Children’s Defense Fund also play a vital role in helping the state set the agenda for health equity efforts. The Ohio Statewide Health Disparities Collaborative, led by the Children’s Defense Fund, has brought together more than 20 diverse organizations, as well as representatives from major foundations like Kaiser, Kellogg and Kresge. The collaborative’s Dec. 11 roundtable at the Cleveland Clinic drew 400 people participants to discuss health disparities, funding sources, and promising model programs. They also heard a talk by Dr. Camara Jones, CDC’s research director on the social determinants of health.

Ron Browder, executive director of the Children’s Defense Fund’s Ohio Chapter, believes that ODH is “moving in the right direction” in its health equity efforts. Still, he stresses that the department must nourish partnerships with wide variety of organizations. “Groups like ours can help set priorities because we are out in the community working with families every day.”

For more information on Ohio’s health equity initiatives:

Ohio Department of Health:  http://www.odh.ohio.gov/


ODH Health Equity homepage:  http://www.healthyohioprogram.org/healthequity/equity.aspx


Ohio Commission on Minority Health: http://mih.ohio.gov/

Health leaders in Oklahoma know very well that that their state faces an uphill battle to gain ground in health equity.

The United Health Foundation reported that Oklahoma’s health ranking was 43rd in the U.S. in 2008, noting in particular the high prevalence of smoking and the very limited access to primary care physicians. The Oklahoma State Department of Health’s own 2008 State of the State’s Health Report also noted that the state was among the nation’s leaders in deaths from heart disease and stroke, with particularly high rates among the state’s black population.

But over the last two years in particular, Oklahoma has gone well beyond simply citing these sobering figures and has instead launched an all-out campaign to call attention to the causes of the state’s longstanding health problems.

Says Neil Hann, chief of the Community Development Service in the Oklahoma State Department of Health (OSDH): “We’re in that southern tier of states where a great many health problems can be traced to such factors as inadequate transportation system, which limits access to primary care, and extensive poverty linked to the failure of so many to complete even a high school education.” He adds that nearly 20% of residents have no health insurance.

**Looking for a HERO**

Clearly, the growing realization of the impact of such social determinants on health status, reinforced by the work of such groups as the Oklahoma Task Force to Eliminate Health Disparities, have made a strong impression on the State’s nine-member Board of Health. Though the State Department of Health already maintained an Office of Minority Health, the board in June of 2007 recommended the establishment of a special office of Health Equity and Resource Opportunities (HERO) to tackle health inequities that go beyond racial disparities.

Residing within the OSDH’s Community Development Service, HERO was quick to launch an aggressive Oklahoma Health Equity Campaign statewide to raise public awareness about how social determinants can lead to poor health outcomes. With strong support from State Health Commissioner Terry Cline, HERO also has been a catalyst within state government for emphasizing the role that other departments can play in closing health disparity gaps. OSDH’s new mantra: Education, transportation and housing policies are also health policy.

HERO Director Marisa New Wells notes that since March 2008 her office has held more than 40 community-based meetings with all sorts of organizations to discuss the health equity issue and gather opinions from the grass roots. Typically, such sessions include a screening of the PBS film series, “Unnatural Causes: Is Inequality Making Us Sick?”

**Expanding the partnership base**
HERO’s major partner in this effort is the Oklahoma Turning Point Council. One of 21 state
councils initially funded in 1998 by the Robert Wood Johnson Foundation, Oklahoma Turning
Point has grown over the years from 3 member organizations to 66. “The council provides a
readymade infrastructure for our health equity campaign and ensures that we get the views of
very diverse organizations,” says Hann. “That will help prevent a situation where government
simply develops cookie cutter solutions to health disparity problems.”

“In the meetings we have in the communities, we take a roots-up rather than a top-down
approach,” adds Sue Moore, a member of Turning Point’s advisory council. “It has to be that
way because the needs of these communities differ so much. For some, it might be obesity; for
others, the concerns could be teen pregnancies or nutritional programs for the elderly.”

With 77 counties to reach, Wells sees the campaign as a longstanding initiative that needs to
attract even more partner organizations. “We have to take this message to many more groups –
churches, universities, companies, tribal governments, nonprofit organizations, community
health boards and more,” says Wells. Her office maintains continuing contact with partner
organizations through web links that provide the latest information from CDC and other sources
on health equity.

Already, the campaign’s community meetings have generated a growing consensus on several
key health-related issues that the state must tackle in coming years. Among them:

- The need for more health education programs in the state’s schools to counter such
  problems as obesity and teen pregnancies.
- New measures to attract full-line grocery stories to the state’s urban and rural “food
  deserts.”
- More funding for public transportation and increased awareness of planning that includes
  “walkable” and “bikeable” communities.

“It means a lot to have state health care leaders, such as Commissioner Cline, come out into
communities both to listen, as well as to stress the necessity of looking at the whole variety of
factors that influence health, such as transportation, jobs and economics,” says Susan Waldron, a
health educator representing three northeast Oklahoma counties. “We’ve gathered a lot of very
valuable information, and I’m anxious to see the action steps that will follow.”

Hann notes that legislation is already being proposed to increase funding for public transit in
Oklahoma City, which lags comparable-sized cities like Albuquerque and Little Rock in public
transit networks. Also being proposed: tax incentives for grocery establishments that locate in
economically-depressed areas.

**Strategy for improvement**

Beyond the Health Equity Campaign, Oklahoma’s renewed focus on health disparities has also
become a core piece in an even wider state effort: The Oklahoma Health Improvement Plan.
Resulting from a coordinated effort involving the state legislature and Board of Health, the plan will address several flagship issues that contribute to Oklahoma’s poor health status, including the social determinants that impact health. The plan will also target “resources needed to expand availability of health-producing factors.”

“This is the first time that health equity issues have been in the forefront of state health improvement strategies,” says Hann, who adds that a new Governor’s task force on eliminating health disparities will also be issuing a new report in 2010.

Meanwhile, HERO is serving as a lead partner in programs that target underserved populations. These include the Governor’s Interagency Council on Homelessness, which is analyzing resources and programs, and an evidence-based self-management program that helps groups like the elderly and newly released prisoners manage such chronic conditions such as heart disease and diabetes. Hann expects more such action programs as priorities surface from the Health Equity Campaign and the Health Improvement Plan.

Not only is HERO reaching out to other state and local government entities to underscore their role in health, but such agencies in turn are beginning to ask HERO to participate in their own planning processes. For example, Wells has been asked by the Regional Transit Dialogue group for Central Oklahoma to participate as a partner in its committee on land use and transportation policy.

“It’s very significant when such groups invite us to the table,” says Hann. “That wouldn’t have happened two years ago.”

For more information on Oklahoma’s health equity initiatives:

Oklahoma State Department of Health: http://www.ok.gov/health/

Health Equity and Resources Opportunities: http://www.ok.gov/health/Community_Health/Community_Development_Service/Health_Equity_&_Resource_Opportunities/

Oklahoma Health Equity Campaign: http://www.ywca.org/site/pp.asp?c=djIMI0POKvG&b=5071945

Oklahoma Health Improvement Plan: http://www.ok.gov/health/Organization/Board_of_Health/OHIP.html

Office of Minority Health: http://www.ok.gov/health/Community_Health/Community_Development_Service/Minority_Health/index.html

Oklahoma State of the State Health Report:
http://www.ok.gov/health/pub/boh/state/index.html

Oklahoma Task Force to Eliminate Health Disparities:
At a time of limited resources, officials at the Virginia Department of Health (VDH) know that it is more important than ever to channel resources to areas most in need.

To accomplish that goal, VDH is harnessing methods ranging from sophisticated Geographic Information Systems (GIS) to identify areas of poor health and social outcomes to establishing a new Healthcare Workforce Development Authority to alleviate shortages in medical professionals.

Increasingly, too, VDH is reaching out to other Executive Branch agencies, such as Housing and Community Development, Education and Transportation, to help shape policies that can impact the health of Virginians.

“Across VDH, the focus on health equity has become much more explicit,” says Michael Royster, MD, MPH, director of the Office of Minority Health and Public Health Policy. “Our State Health Commissioner, Dr. Karen Remley, has been a big proponent of the issue and has made it a central part of department planning and strategy.”

**Leading the charge**

While Dr. Royster emphasizes that health equity is the responsibility of the entire department, two divisions reporting to him spearhead many VDH efforts to reduce health disparities: the Division of Health Equity and the Division of Primary Care and Rural Health. His office also works closely with the Commissioner’s Minority Health Advisory Committee (MHAC), composed of 20 health and community leaders from throughout the Commonwealth, on issues ranging from infant mortality to obesity. Members also have helped VDH raise awareness about the social determinants of health by organizing community events to discuss the “Unnatural Causes” PBS series, as well beginning to work with the state’s 35 local health districts to ensure that health equity is a key element in MAPP (Mobilizing for Action through Planning and Partnerships) assessments.

“If you hope to address the social determinants of health, you need to get the entire community on board and involve a tremendous diversity of influences,” says Gloria Addo-Ayensu, MD, MPH, chair of the advisory committee and director of the Fairfax County Department of Health. “The health department can’t do it alone.”

The Office Co-chaired and the advisory committee was a key backer of a September 2009 Health Equity Conference in Richmond, which featured national experts and drew some 400 people. Karen Reed, director of the VDH Division of Health Equity, notes that a conference session on federal CLAS (Culturally and Linguistically Appropriate Services) standards has spawned interest in a statewide collaborative to strengthen medical interpreter services, including
certification. Also coming out of the conference: a new “Advancing Health Equity” blog on the NING social networking site and webinar series.

“The mission of the advisory committee aligns with our own mission—promoting health equity,” says Reed. “MHAC’s subcommittees focus on community engagement and legislation, and members make recommendations to the Commissioner of Health on an ongoing basis.”

Advisory committee member Lucie Ferguson, PhD, MPH, director of Community Health Advocacy for the Bon Secours Richmond Health System, says that “Dr. Royster has made a big difference in organizing the department around the issue of health equity.” Still, she points to major challenges facing the state, ranging from infant mortality and poverty to vestiges of racism that she believes contribute to stress and high rates of stroke among blacks.

Such challenges are documented every two years in VDH’s Health Equity Report. The 2008 version noted that 25% of blacks live in high poverty census tracks in the state, compared to 6% or less for all other racial and ethnic groups. It also showed the relationship between lower education attainment and higher mortality rates. And looking at deaths from specific diseases, the document reported that blacks had a 25% higher mortality rate than whites from heart disease, a 23% higher rate from cancer, and a 150% higher rate from cerebrovascular disease.

For the 2010 version of the Health Equity Report, VDH hopes to include a health opportunity index and will identify local areas that are in most need of attention for targeted resources and programs using GIS.

The 2008 Health Equity Report also underscored the problems of Virginia’s rural areas, where nearly 15% of the population lives in poverty census tracts, versus 8.7% who live in impoverished urban areas. Both access and quality of care remain major issues in rural parts of the state, says Kathy Wibberly, PhD, director of the VDH Division of Primary Care and Rural Health.

To tackle such problems, VDH in 2008 joined with the Virginia Rural Health Association in formulating a State Rural Health Plan, a three to five year strategy forged in collaboration with 50 partners, including healthcare providers, rural legislators, and community groups. “The partners really took ownership of the plan,” recalls Wibberly, “and we were there to facilitate the process.”

Wibberly notes that the plan focuses on four key areas: workforce development, access to care, data on rural health needs, and quality of care. Already, the plan has triggered new legislation creating a Health Workforce Development Authority. Its primary mission: Fill the pipeline of medical personnel serving in rural areas through programs ranging from education on health professions in schools to creation of new residency programs and recruitment assistance for local health districts.

By the Numbers

No matter where VDH is targeting its efforts – rural or urban – the department is increasingly relying on GIS (Geographical Information Systems) software to identify high priority target
areas (HPTAs). Led by epidemiologist Ken Studer, PhD, the department maintains geocoded databases of health professionals and uses GIS mapping to find census tracts and even neighborhoods that exhibit poor health outcomes, as well as adverse social determinants.

Explains Dr. Royster: “In Richmond city, GIS shows that the clustering of infant deaths occurs in the historically segregated part of the city where you also have high poverty, crime, and public housing. And in rural areas, we can use it to see where plant emissions might be contributing to cases of asthma.”

Wibberly’s division first used GIS to designate areas with shortages of medical personnel and healthcare facilities. “We have mapped not only primary care providers, but also dentists, psychiatrists and other specialties, as well as the typical distances people must travel to these providers,” says Wibberly.

GIS data also underscored serious problems in getting timely medical treatment for stroke victims in rural areas. As a result, Wibberly’s division launched a pilot telemedicine program supported by a federal Flex HIT grant. In this effort, a radiology and neurology team at a major medical center review CT scans sent from a rural hospital and confer by video conference with the family and patient. They also prescribe needed medication. VDH is now preparing to roll out the program to more rural hospitals.

Wibberly’s division also was instrumental in setting up the Virginia TeleHealth Network. Among its key initiatives: psychiatric services for rural patients delivered by a team located at the University of Virginia.

Dr. Royster sees GIS as perhaps the most valuable new tool available to his office. “We are just beginning to realize its potential,” he says. “With GIS, you can really home in on areas where poor health outcomes are linked to adverse social, economic and environmental factors, and this helps VDH, local health districts, and community groups better focus their resources.”

The ability to identify high priority target areas supports the Office’s focus on encouraging and supporting community based participatory approaches (CBPA) to promoting health equity. CBPA values collaborative partnerships among diverse community representation to identify community priorities and address them by building on the community’s assets. “We view this as a critical strategy to promote health equity, and we have provided technical assistance to communities around the Commonwealth interested in this approach,” stated Dr. Royster.

Creating New Alliances

In addition to such tools, VDH is reaching out more to other agencies. For example, the department is exploring with the Department of Housing and Community Development how health equity goals can be integrated into the decision-making process for awarding Community Development Block Grants.

Also helping to promote cross-agency cooperation is a new federal Healthy People 2020 Evaluation Grant, administered by the Division of Health Equity. “Commissioner Remley is
giving presentations on Healthy People to state agencies, as well as to legislators and the Council on Virginia’s Future to demonstrate their role in influencing the social determinants of health,” says Dr. Royster. “One of our goals is to have other agencies adopt one or more of the Healthy People 2020 objectives as part of their own strategic plans.”

Meanwhile, VDH wants to work more closely with the General Assembly by using new approaches, such as Health Impact Assessments, in order to review and analyze legislation. In addition, VDH is partnering with the University of Virginia’s Department of Health Sciences to develop a webinar for local health districts and other community partners on how they can use health impact assessments in their areas.

Virginia also is taking new steps to close gaps in health insurance coverage. The Division of Primary Care and Rural Health maintains an Insure More Virginians web site to help people find more affordable insurance. VDH has also launched a pilot program, funded by a federal State Health Access grant, to extend insurance coverage to employees of small businesses.

To Dr. Royster, these and many other efforts all tie together in a four-pronged approach to achieving health equity. “Our work is initially defined by the data, which has a strong influence on how we move forward. From there, we focus on access to care and community health equity issues. Finally, we pursue broader public policies and how they can shape health equity.”

For more information on Virginia’s health equity initiatives:

Virginia Department of Health (VDH)

VHD Office of Minority Health and Public Health Policy
http://www.vdh.virginia.gov/healthpolicy/about.htm?mode=printable

Office of Minority Health and Public Health Policy Strategic Plan

Office of Minority Health and Public Health Policy Annual Report

VDH Division of Health Equity

Division of Health Equity Toolkit
http://www.vdh.state.va.us/healthpolicy/healthequity/unnaturalcauses/resources.htm

Unequal Health Across the Commonwealth (2008 Report)

Rural Health Plan 2008
http://www.va-srhp.org
Spatial Analysis and High Priority Target Areas

Spatial Analysis of Health Data and Development of High Priority Target Areas

Commissioner’s Minority Health Advisory Commission
http://www.vdh.state.va.us/healthpolicy/healthequity/MHAC.htm

Advancing Health Equity blog
http://healthequityinva.ning.com/