CALL TO ACTION FOR HEALTH EQUITY

DATA DRIVEN INTERVENTIONS
We can use data to discover which groups of people may need extra support from our organization and partners.

CULTURAL COMPETENCE & RESPONSIVENESS
We can assess and train ourselves to have more empathic relationships with people of different backgrounds.

COMMUNITY ENGAGEMENT
We can partner with communities to increase the impact of health improvement interventions.

INCLUSIVE DECISION MAKING
We can invest in maximizing opportunity for diverse groups of the population to be included at all levels of decision making.

Health Equity Lunch and Learn Series: Applying an Equity Lens to Decision Making

Dr. Rick Foster
Executive Director,
Catalyst for Health
rfoster@scha.org
Viewing a Healthier South Carolina for All Through the Equity Lens
from a 50 year viewpoint
"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman because it often results in physical death."

March 26, 1966
• Health equity is achieved when every person has the opportunity to “attain his or her full health potential” and no one is “disadvantaged from achieving this potential because of social position or other socially determined circumstances.”

• Health inequities are reflected in differences in length of life; quality of life; rates of disease, disability, and death; severity of disease; and access to treatment.
Understanding Health Equity

Equality doesn’t mean Equity
FAIR OR POOR HEALTH STATUS BY RACE/ETHNICITY AND INCOME, 2007

Share reporting fair or poor health:

- White, Non-Hispanic
- Hispanic
- African-American, Non-Hispanic

![Bar chart showing health status by income and race/ethnicity with specific percentages and notes on data sources and references.]

**Figure 2.**

Disparities in Access to Care

Percent of access measures for which each group experienced worse, same, or better access to care.

Low-income individuals and people of color often experience worse access to care compared to higher-income and white people.

- **Poor vs. High Income**
  - Poor: 89%
  - High Income: 63%

- **Hispanic vs. White**
  - Hispanic: 62%
  - White: 38%

- **AI/AN vs. White**
  - AI/AN: 64%
  - White: 21%

- **Black vs. White**
  - Black: 44%
  - White: 17%

- **Asian vs. White**
  - Asian: 39%
  - White: 18%

- **65+ vs. 18–44**
  - 65+: 73%
  - 18–44: 18%

**Note:** AI/AN = American Indian or Alaska Native

**Source:** Kaiser Family Foundation analysis of AHRQ, National Healthcare Disparities Report, 2011.
The Geography of Upward Mobility in the United States
Chances of Reaching the Top Fifth Starting from the Bottom Fifth by Metro Area

Note: Lighter Color = More Upward Mobility
Download Statistics for Your Area at www.equality-of-opportunity.org
Overall Local Health System Performance: Scorecard Ranking, 2016

Overall performance, 2016
- Top quintile (61 local areas)
- Second quintile (61)
- Third quintile (63)
- Fourth quintile (61)
- Bottom quintile (60)

Source: Commonwealth Fund Scorecard on Local Health System Performance, 2016 Edition.
South Carolina’s Health

People in **41** other states have better health than people in South Carolina.

...people who live in low-income neighborhoods or rural areas, and people of color have even worse outcomes.

...our children are the first generation projected to live shorter lives than their parents.

Hundreds of people and organizations in our state are doing great work,

..but we have not been as coordinated and aligned as we should be.

For the first time in our state’s history. We are working together to change this.
Social Determinants of Health

- conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks
Large geographic areas and portions of suburban areas of southern Dallas County often suffer from disproportionate disease rates and substantial resource deserts. These areas lack key resources that other portions of the county have, including access to health services, safe environments, and access to healthy foods.

“Communities with low socioeconomic status often have no community center, no library, no churches, no place for people to go. The only possibilities are the new schools that are empty at night and on the weekend.” –Key Informant

Source: KarBel Multimedia for Dallas County Health and Human Services
“Individually, we are ONE DROP. Together, we are AN OCEAN.”
- Ryunosuke Satoro
Alignment with goals is our primary way of impacting health in SC
The Alliance for a Healthier South Carolina

Mission:
Coordinating action on shared goals to improve the health of ALL people in South Carolina.
Organizational structure (2016)

- Policy and Advocacy Team
- Development Team
- Health Equity Team
- Communications Team
- Alliance Members & Partners
- Alliance Members' Senior Reps.
- Leadership Team
- Operations Team

@HealthierSC  #HealthierSC  HealthierSC.org
Our Common Agenda for Health Improvement

HEALTHY BABIES
Improve the health of moms and babies from preconception to the first year of life.

HEALTHY CHILDREN
Improve the health and educational outcomes of children.

HEALTHY BODIES
Improve the physical health through healthy nutrition and physical activity. Improve physical health through enabling access to high quality primary care.

HEALTHY MINDS
Improve behavioral health through improved access to appropriate behavioral health services and other necessary clinical and support services.

FOR ALL PEOPLE IN SC
Everyone with the same probability of attaining the best health status, independent of gender, race, sexual orientation, neighborhood, disability, ethnicity, education attainment or socioeconomic status.

AT A LOWER PER-CAPITA COST
Reduce the per-person cost of healthcare in the state (when accounting for all public and private healthcare expenses).
Our equity metrics

- Racial Disparity in Low-Birthweight 2014
- Economic Disparity in Low-Birthweight 2014
- Economic disparity in failure to read at grade level in 3rd grade - 2014
- Racial Disparity in Preventable Emergency Department visits - 2014
- % of low-income adults who spent 8 days or more feeling mentally ill last month - 2014
Solving the health equity puzzle

Timely and adequate resources to care for people

Navigation and other support services

Access to Adequate Coverage

High Quality Care that is patient and community centered
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Early success of the Call to Action

- Over 60 partners including 40 SC hospital systems
- Webinar series sharing how South Carolina champions are improving health equity in SC: HealthierSC.org/Webinars
  - Cross-cultural communication
  - How to include an equity lens in recruitment
  - Training community members to serve on boards
  - How to stratify data for health equity in publicly available sources
  - How to meaningfully engage community members
  - How to include an equity lens in decision making
  - Impact of implicit bias and micro-aggressions on health disparities
- 7 Case studies about how to decrease disparities due to race, income, and behavioral health co-morbidity at HealthierSC.org/Resources
- Created list of South Carolina peer mentors willing to help others in the process of improving health equity: HealthierSC.org/priorities/health-equity/
Proportion of students not reading at grade level by 3rd grade

Worst results

In half of the schools, there are at least 70% of children NOT reading at grade level.

In the best performing school for low-income children, 40% of low-income children are NOT reading at grade level in 3rd grade (Sullivan).

Less than 10 Low-income children in 3rd grade at Buist Academy.

There are 26 schools with no more than 10 low-income children in 3rd grade.
Where to focus on African American LBW to improve overall birth outcomes for the zip code?

High LBW rate, high volume, very high racial disparity

### Low-Birthweight in Tri-County 2010-2014

<table>
<thead>
<tr>
<th>Zipcode</th>
<th>LBW</th>
<th>LBWR</th>
<th>Zipcode</th>
<th>LBW</th>
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<tbody>
<tr>
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<td>17%</td>
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<td>9%</td>
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<td>13%</td>
<td>29481</td>
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<td>5%</td>
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<td>210</td>
<td>9%</td>
<td>29469</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Where to focus on African American LBW

- **West Ashley**: 29464, 2,553 births, 6% LBW, 13% Black LBW, 144% higher than White LBW
- **Mt. Pleasant**: 29407, 2,300 births, 6% LBW, 15% Black LBW, 158% higher than White LBW
- **Between peninsula and Citadelle Mall**: 29405, 2,035 births, 6% LBW, 15% Black LBW, 158% higher than White LBW
- **Monks Corner, Windwood, Tarry Town**: 29461, 2,218 births, 7% LBW, 17% Black LBW, 150% higher than White LBW
- **North Charleston**: 29410, 1,318 births, 5% LBW, 14% Black LBW, 161% higher than White LBW
- **Hanahan**: 29455, 1,256 births, 7% LBW, 13% Black LBW, 136% higher than White LBW
- **North of Ashley Phosphate Rd, right of Ashley river, left of I-26**: 29460, 1,631 births, 5% LBW, 15% Black LBW, 172% higher than White LBW

*Note: LBW = Low Birth Weight, LBWR = Low Birth Weight Rate, X% = Percentage increase*
**Equity Call to Action - Obesity**

1: **Stratify data** to identify what populations to target.

2: Maximize the potential of **diversity** in your organization to develop **culturally sensitive** solutions **WITH the community**.

### South Carolina Obesity Rates

<table>
<thead>
<tr>
<th>Population</th>
<th>Obesity Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>27.6%</td>
</tr>
<tr>
<td>Black</td>
<td>43%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>36.1%</td>
</tr>
<tr>
<td>Less than $25,000</td>
<td>39.2%</td>
</tr>
<tr>
<td>$25-$49,000</td>
<td>34.5%</td>
</tr>
<tr>
<td>$50-$74,000</td>
<td>32.5%</td>
</tr>
<tr>
<td>$75,000 or more</td>
<td>29.4%</td>
</tr>
<tr>
<td>Urban</td>
<td>31.8%</td>
</tr>
<tr>
<td>Suburban</td>
<td>30.9%</td>
</tr>
<tr>
<td>Rural</td>
<td><strong>34.7%</strong></td>
</tr>
</tbody>
</table>
**The health equity ripple effect**

Obesity/Chronic Disease of the mom prior to conception is a risk-factor for Low-birthweight.

Low-birthweight is a risk factor for Infant Mortality and for difficulty to learn.

Difficulty to learn is a risk factor for high-school graduation.

High-school graduation is a major socioeconomic determinant of health.
SC Hospital Association is responding to the challenge

- Over 40 health system CEOs committing to the Health Equity call to action
- All SC health systems provided with a baseline equity-based readmission disparity gap profile
How the SC Hospital Association is responding to the challenge

- Co-launching State Call to Action with AHA National Call to Action.
  - 40 hospitals are working on a 9-month timeline

- Creation of a hospital-specific racial disparity readmission dashboard.

- Inclusion of at least one equity-focused speaker in all major SCHA events.

- Statewide Quality Advisory Council and Nurse Leaders Association challenged members to take an Implicit Bias test.

- Attending Mass General Disparity Leadership Program with the purpose of modifying interview guides (and guidelines for interviewer) for readmitted patients to better identify barriers in trust.

- Developing cultural competency curriculum for hospital staff/physicians

- New unit at the association focused on Population Health Improvement.
### 30-day Readmission Rate by race to any SC hospital

<table>
<thead>
<tr>
<th>Overall</th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharges</td>
<td>Readmissions</td>
<td>Discharges</td>
</tr>
<tr>
<td>525,613</td>
<td>48,593</td>
<td>340,767</td>
</tr>
<tr>
<td>158,593</td>
<td>17,136</td>
<td></td>
</tr>
</tbody>
</table>

**Overall Readmission Rate**
- 9.25%

**White Readmission Rate**
- 8.78%

**Black Readmission Rate**
- 10.81%

1. Stratify the data
Your hospital is being compared to 14 other hospitals with more than 100,000 discharges.

### Racial Disparity Gap

Your hospital's Black readmission rate is 23% higher than your White readmission rate.

- **Best** (Lowest Disparity)
- **Worst** (Highest Disparity)

### Potential Overall Readmission Rate if racial disparity gap is closed

If your hospital eliminated the racial disparity, your overall readmission rate would decrease by 7% to:

<table>
<thead>
<tr>
<th>Overall Readmission Rate</th>
<th>Potential Overall Readmission Rate if racial disparity gap is closed</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.63%</td>
<td></td>
</tr>
</tbody>
</table>

You would avoid 3215 readmissions among your Black patients.

And you would move your Overall Readmission Rate from Orange to Yellow in the comparative dashboard.

2. Maximize the potential of diversity in your organization to develop culturally humble solutions WITH the community.
The Neighborhood and The Need

The 5.6 square mile area of CPN is marked by under-education, teenage pregnancy, poor healthcare, violent crime, unemployment, and intergenerational poverty.

We aim to break that cycle.

Note: 2016 Federal Poverty Line for a family of 4 (200% FPL) = $48,500
The Path to Achieving Health Equity

What social and economic factors must be addressed on the continued path to achieving Health Equity?

Discrimination/Minority Stressors

Food Security and access to healthy foods

Housing

Educational Opportunities

Quality Affordable Healthcare

Environmental Quality

Neighborhood Conditions

HEALTH is affected by

Stable Income & Job Security

Health Equity aims to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

The Health Equity Institute
http://thehealthequity.sfsu.edu
1600 Holloway Avenue, HSS 359
San Francisco, CA 94132
P: 415-405-2540

Find us on:

HealthierSC.org

The Roadmap to Reduce Disparities

A Guide for Healthcare Organizations

From Finding Answers: Disparities Research for Change

Implement Change

1. Link Quality & Equity

Equity is linked to quality improvements. Even when access to care is equal, racial and ethnic minority patients tend to receive lower quality care than White patients. Even when health outcomes improve across the entire patient population, disparities between racial/ethnic groups can remain or even worsen.

2. Create a Culture of Equity

It’s not enough for people to know that disparities are a problem; they need to recognize that disparities exist among their own patients and take responsibility for addressing those disparities. That’s the beginning of all equity work.

3. Diagnose the Disparity

It’s important to understand why disparities exist and determine which causes of disparities can be addressed. Consider the issues relevant to your patient populations that might contribute to disparities in care and outcomes. Assemble a team that includes patients, institutional leaders, and frontline staff to conduct a root-cause analysis. Make sure to recognize and support equity champions in your organization.

4. Design the Activity

Designing an equity program requires creativity and innovation. It means finding what you have learned in a root-cause analysis to sites of action and resources. There is no single right answer!

5. Secure Buy-in

Buy-in is a commitment demonstrated through action. You are more likely to succeed if you have the concrete support of all stakeholders. Be specific in what you ask and walk away with a plan.

6. Measure change. You’ll need evidence that you have made a difference. Create a timeline for evaluation and measurement.

Be adaptable. Strike a balance between adhering to your plan and adapting it as needed. Equity improvement is a continuous process.

The Roadmap’s six-step framework helps integrate reducing disparities into all health care quality improvement efforts. It is designed to be flexible and can get on the road where they need to. Its goal is to support a thoughtful and comprehensive approach to achieving equity, even though the causes of disparities may vary across regions or patient populations.

The Roadmap draws upon lessons learned from Finding Answers’ 55 grantee projects and 11 systematic reviews of the disparities-reduction literature.

www.solvingdisparities.org

Robert Wood Johnson Foundation

LINK CREATE DIAGNOSE DESIGN SECURE IMPLEMENT
Key health equity-based improvement actions

• Establish multi-sector health equity-focused coalitions at the community level (collective impact in action)
• More fully understand the communities you represent and serve using equity-stratified data
• Focus on the whole population, not just those who are seeking care/services at any given time
• Segment vulnerable/high risk populations for targeted improvement programs and interventions
Equity-focused health improvement actions

• Build cultural competency within your workforce and cultural humility within your organizational culture

• Identify policy and system changes that can most impact specific equity gaps (“health in all policies”)

• Invest in upstream solutions focused on the social determinants of health

• Give an active voice to those with lived experience by meeting w/ at risk populations where they live
Equity-focused health improvement actions

• Actively engage, integrate and support existing community-based social programs and services

• Fully establish the community health hub and pathway model as primary access point for at risk populations

• Support and participate in health equity research that includes specific vulnerable populations

• Accept and embrace that the major health and social equity gaps will require complex solutions and collective action