A Government Led Model for Health Equity and Social Determinants of Health

LaQuandra S. Nesbitt, MD, MPH
Director, Louisville Metro Department of Public Health and Wellness
Assistant Professor, University of Louisville School of Public Health and Information Sciences
January 16, 2014
Agenda

• Health Disparities v. Health Equity
• Challenges to “Operationalizing” Health Equity
• History of Louisville Metro’s Center for Health Equity
• Building the Right Health Equity Infrastructure
• Tips for Success
• Discussion
HEALTH DISPARITIES V. HEALTH EQUITY
Healthy People 2020: Definitions

Health Equity:
• *IS* the “attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address [avoidable inequalities, historical and contemporary injustices](http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx), and the elimination of health and health care disparities.”

Health Disparity:
• *IS* “a particular [type of health difference that is closely linked with social, economic, and/or environmental disadvantage](http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx). Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”
Defining Disparities

• Health
  – Incidence
  – Prevalence
  – Morbidity
  – Mortality

• Healthcare
  – Services
    • Access to providers/hospitals
    • Access to procedures/medications
  – Insurance
Causes of Disparities

• Operation of Healthcare Systems
  – Cultural or linguistic barriers
  – Fragmentation of healthcare systems
  – Incentives to contain costs
  – Quality and type of facilities where minorities receive care

Causes of Disparities

• Clinical Encounter
  – Bias (or prejudice) against minorities
  – Greater clinical uncertainty
  – Beliefs (or stereotypes) about the behavior or health of minorities

Causes of Health Inequities

• Socioeconomic Status
  – Poverty
  – Unemployment
  – Institutional Racism
  – Education
  – Neighborhood Segregation
## Education, Health & Wealth

### Behavior Risk

<table>
<thead>
<tr>
<th>Behavior Risk</th>
<th>No High School</th>
<th>High School/GED</th>
<th>Some College</th>
<th>College or More</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoke Everyday</strong></td>
<td>52.0%</td>
<td>43.9%</td>
<td>40.0%</td>
<td>20.4%</td>
</tr>
<tr>
<td><strong>Not Eating 3 or More Vegetables Daily</strong></td>
<td>95.7%</td>
<td>94.3%</td>
<td>90.3%</td>
<td>81.5%</td>
</tr>
<tr>
<td><strong>No Physical Activity Outside of Work</strong></td>
<td>33.1%</td>
<td>21.6%</td>
<td>15.2%</td>
<td>11%</td>
</tr>
</tbody>
</table>

*People Ages 25-65 Reporting Risk Behaviors, Louisville Metro BRFSS, 2009*
CHALLENGES TO OPERATIONALIZING HEALTH EQUITY
“Operationalize” Health Equity - The Challenge

• Placing responsibility for achieving health equity on healthcare providers and healthcare delivery systems
  – Hospital based and health center projects tend to focus on health care disparities designed to impact health outcome disparities
“Operationalize” Health Equity-The Challenge

• Lack of awareness of health disparities/inequities possibly due to a primary focus on education and civic engagement among disparate populations
  – Only 4 percentage point increase in US adults who are aware of racial and ethnic disparities that affect African Americans and Hispanics or Latinos from 1999 to 2009
  – 89% of African Americans were aware of African American and white disparities versus 55 percent of whites

\[^{1}\text{Benz J et al. Awareness of Racial and Ethnic Health Disparities Has Improved Only Modestly Over A Decade Health Affairs, 30, no.10 (2011):1860-1867} \]
“Operationalize” Health Equity-The Challenge

• Minimal research and evaluation to link local health outcomes and socioeconomic factors
  – Moving theory to practice—and showing it works!

• Integrated approach to health equity practice
  – How can health equity be intertwined with all policies, programs, and practices

• Lack of recognizing changing funding streams
  – Funding to improve health outcomes doesn’t only come from health focused agencies—and that’s okay!
HISTORY OF LOUISVILLE’S CENTER FOR HEALTH EQUITY
Center for Health Equity

- Established in 2006
- First of its kind in the Nation
- Engage Community As Advocates
  - Awareness
  - Dialogue
  - Action
Goals and Objectives

• Establish a presence in “the community”
• Educate and engage racial and ethnic minorities living in under-resourced neighborhoods
• Be the catalyst for a social justice movement focused on health
• Secure funding from the private sector to address social determinants of health and the impact of racism on health
Early Accomplishments

• Partnered with a local health care system to host a Health Equity Summit
• Convinced the community that health was more than health care
• Created awareness of impact of racism on health
• Leveraged private funding to address racial healing and the built environment
• Cohort of ambassadors for health equity
Louisville Racial Healing Initiative

- Healing
- Undoing Racism
- Youth Leadership
- Healing History

COMMUNITY

CONVERSATIONS

Structural Racism Recommendations
What Happened 5 years Later?
We Need Support!!!
Center for Health Equity

- Inform, educate, and empower people about health issues.
- Mobilize community partnerships to identify and solve health problems.
- Develop policies and plans that support individual and community health efforts.
- Assure a competent public health and personal healthcare workforce.
- Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
- Research for new insights and innovative solutions to health problems.

Are we actually doing this?
How the Pieces Fit Together

Community Engagement & Partnerships

Health Equity Institute

Research & Evaluation

Health Equity Institute

The Center for Health Equity

Public Health & Wellness

Louisville Metro
Health Equity Report 2011

- Change the Context
- Baseline on Social Determinants at the Neighborhood Level
- Promote a Health-in-All-Policies approach
- Where we live, shouldn't determine how long we live!

BECAUSE
- Health Equity is Everybody’s Work
Where are we now?

- Support from Mayor
- Commitment from Agency Leadership
- Engaged and Activated Community
VIOLENCE PREVENTION CASE STUDY
WHO Definition of Violence

The intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation.
Public Health Approach

• US Surgeon General Julius Richmond declared violence a public health crisis in 1979

• Apply public health principles such as epidemiology
  – Focusing on health effects, characteristics, root causes and influences in a well-defined population

• Assure the provision of services
  – Address physical and mental health needs
  – Victim and perpetrator and their support systems/networks
Types of Prevention\(^1\)

- **Primary prevention** – approaches that aim to prevent violence before it occurs.
- **Secondary prevention** – approaches that focus on the more immediate responses to violence, such as pre-hospital care, emergency services or treatment for sexually transmitted diseases following a rape.
- **Tertiary prevention** – approaches that focus on long-term care in the wake of violence, such as rehabilitation and reintegration, and attempts to lessen trauma or reduce the long-term disability associated with violence.

Violence Socioecological Model

Impact of Violence

• Community violence can lead to\textsuperscript{2}
  – Disrupted education
  – Lower job prospects
  – Fragmented relationships
  – Legal problems
  – Incarceration
  – Serious injury, illness, and death

Impact of Violence

• Exposure to violence in the first years of childhood can reduce potential IQ by as much as 10 percent²

• Children exposed to violence can²
  – Become hypervigilant
  – Believe violence is normal
  – Become violent to avoid being perceived as weak

Impact of Violence

• Adults who were exposed to violence as a child are more likely to report\(^3\)
  – Early initiation of smoking and sexual activity
  – Multiple sexual partners and teen pregnancy
  – Intimate partner violence
  – Alcoholism and alcohol abuse
  – Depression and suicide attempts
  – Liver, heart, and lung disease
  – Poor health and diminished quality of life

\(^3\)Findings from the CDC Adverse Childhood Experiences (ACEs) Study
Leading Causes of Death

• In 15-34 year olds are unintentional injury, homicide and suicide
  – Reducing violence in this age group can lead to reduced all-cause mortality

• In 2009, the death rate for suicide in Louisville Metro was higher than the death rate for homicide
  – Suicide death rate 13.9 per 100,000
  – Homicide death rate 11 deaths per 100,000
Applying Public Health Approaches to Violence Prevention

• **Define the issue of concern** (ex., behavioral health disparities, impact of violence on health outcomes, health and social wellness factors that contribute to community violence)

• **Provide the documentation** (ex., high rates of homicide/suicide in a particular community, disparities in health and treatment outcomes)

• **Recommend solutions**—and document why there is a good likelihood that those recommendations would be successful

• **Recommend how to implement** the recommendations (partnerships, financial resources)
Health Equity Lens for Violence Prevention

- Allows for shifting beyond a criminal justice approach
- Identifies root causes
- Highlights that inequities are often “bundled”
Health Equity Lens for Violence Prevention

• Community Building
• Education
• Employment and Economic Development
• Health and Social Wellness
• Juvenile and Criminal Justice
BUILDING THE RIGHT HEALTH EQUITY INFRASTRUCTURE
6 Simple Steps

- Define the Issue
- Identify Stakeholders
- Identify Core Functions
- Choose/Develop Leadership
- Identify Resources
- Demonstrate Outcomes
DEFINE THE ISSUE
What is Health?

“Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”

World Health Organization
How Do We Improve Health?

Factors that Affect Health

- **Socioeconomic Factors**
  - Changing the Context to make individuals’ default decisions healthy
- **Long-lasting Protective Interventions**
- **Clinical Interventions**
- **Counseling & Education**

**Examples**
- Eat healthy, be physically active
- Rx for high blood pressure, high cholesterol, diabetes
- Immunizations, brief intervention, cessation treatment, colonoscopy
- Fluoridation, 0g trans fat, iodization, smoke-free laws, tobacco tax
- Poverty, education, housing, inequality

**Impact**
- Smallest Impact
- Largest Impact
Determinants of Health

Health Factors = 50%

- Health Behaviors: 30%
- Clinical Care: 20%
- Social & Economic Factors: 40%
- Physical Environment: 10%

Policies & Programs = 50%
Framework For Public Health & Equity

Social Determinants = 50%

- Upstream Socio-Economic Factors
  - Social Inequalities
    - Class, Race, Ethnicity, Gender, Sexual Orientation, Immigration Status
  - Institutional Power
    - Corporations & other Businesses, Government Agencies, Schools
  - Neighborhood Conditions
    - Physical & Social Environment, Residential Segregation

- Risk Behaviors
  - Smoking, Nutrition, Physical Activity, Violence

- Disease & Injury
  - Infectious & Chronic Diseases, Injury (intentional & un-intentional)

- Mortality
  - Infant Mortality, Life Expectancy

- Health Status
  - Downstream
    - Health Care Access
  - Medical Model
    - Health Status

Socio-Ecological Socio-Economic Factors

Individual Health Knowledge, Genetics

Upstream Downstream
IDENTIFY STAKEHOLDERS
Identify Stakeholders

Local Public Health System

- Police
- EMS
- Providers Serving People with Disabilities
- MCOs
- Health Department
- Faith Based Organization
- Home Health
- Corrections
- Parks
- Hospitals
- Philanthropist
- Schools
- Elected Officials
- Nursing Homes
- Mass Transit
- Environmental Health
- Fire
- Health Care Providers
- Civic Groups
- Community Centers
- Employers
- Economic Development
- Laboratory Facilities
- Drug Treatment
- Mental Health
Identify Stakeholders

Coalition of the Willing

Coalition of the Curious

Coalition of the Necessary
IDENTIFY CORE FUNCTIONS
Identify Core Functions
Identify Core Functions

- Core and essential functions maintain support
- Need to link with the evidence for providing a “service”
- Allows you to meet the “local” community need

Establishes Necessity!
ESTABLISH LEADERSHIP
Two “Schools of Thought”

Health equity can only be achieved when policymakers, government leaders, and elected officials “buy-in”

Health equity can only be achieved when communities disproportionately impacted by inequities are mobilized

Are they Mutually Exclusive?
Community/Non-Profit Led

• Pros
  – Community can take ownership of its issues/challenges
  – aPolitical
  – Able to influence policy through advocacy and lobbying
  – Can lead cultural change more effectively

• Cons
  – Community must be willing to engage
  – Unstable/inconsistent funding sources
    • “strings attached”
  – Risk of diversion from “mission driven” to “funding driven”
  – Viewed as a “desire” of the community and not a “need” of the community
Government Led

• Pros
  – Can require alignment of organizational and legislative policies to support health equity
  – Establish stable funding through budget process
  – Direct contact with policymakers (policy) and elected officials (Policy)
  – Can be naturally embedded in public health infrastructure

• Cons
  – Requires supportive executive branch
  – Requires supportive legislative branch
  – Community members perceive powerlessness
  – Support waxes/wanes with changes in elected and appointed leadership
  – Can get lost or isolated in public health infrastructure
IDENTIFY RESOURCES
Identify Resources

- Are there ongoing/fragmented health equity activities?
- Are there human resources available?
- Are investments being made in all areas of the 10 core functions?
- What are other public and private organizations funding that is consistent with the identified issues and core functions?
- Are foundations and philanthropist interested in health equity (e.g., food deserts, physical activity opportunities)?
Identify Resources

• What funding is the organization eligible to receive?
• Who’s funding health equity at the local, regional, state, and federal level?
DEMONSTRATE OUTCOMES
Demonstrate Outcomes

<table>
<thead>
<tr>
<th>What Did We Do?</th>
<th>How Well Did We Do It?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What Happened as a Result?
TIPS FOR SUCCESS
Tips for Success

• Share responsibilities
  – Recognize and value non-traditional approaches to public health

• Be humble
  – The public health and health care system won’t always get the credit…..and that’s okay!

• Know why your partners do what they do
  …..and decide how you feel about it