Annual Kinsman Conference
Vancouver, WA

“What’s unethical about health disparities?”
Part One

Ella Booth, PhD, MSB
April 17, 2009
It Just Ain’t Fair

“The state of health care in the United States is sadly deficient for many poor people, women and ethnic minority groups.”

-Annette Dula
Agenda

• Causes of health care disparities

• The Health Equities Committee
  – Composition
  – Charge

• Recommendations from Committee
Causes of Health Care Disparities: Access & Barriers to Health Care

• Financial

• Structural

• Cultural
Financial Barriers

• Nationwide, 46 million Americans lack health insurance
• Lack of enough health insurance to cover needed services
• Lack of out-of-pocket resources
• Uninsured costs ~ $125 billion
Oregon

14% of Oregonians are without health insurance
Uninsurance by Self-Identified Hispanics

• 30.7% of all Hispanics are uninsured

• Hispanics percentage of uninsurance 2.5 times non-Hispanic ethnicity.

• Does not include undocumented immigrants!!!
Structural Barriers

- Lack of primary and specialty care providers
- Lack of general continuity of care
- Lack of health care facilities
- Inconvenient locations
- Long waiting times
Cultural Barriers

• Religious/spiritual beliefs
• Lifestyle
• Health Behaviors
• Negative past experiences with health care system
• Language barriers
• Availability of translators
Aim High: Building a Healthy Oregon

• Building Block 1: “Bring Everyone Under the Tent”
• Building Block 2: Set High Standards – Measure & Report
• Building Block 3: Unify Purchasing Power
• Building Block 4: Stimulate System Innovation & Improvement
Aim High: Building a Healthy Oregon

• **Building Block 5: Ensure Health Equity for All**
• Building Block 6: Train a New Health Care Workforce
• Building Block 7: Advocate for Federal Changes
The Healthy Oregon Act

• Appointment of a seven-member OHFB
• Established six committees:
  E&E    Finance
  Benefits    Federal Laws
  Delivery System    Health Equities
The Health Equities Committee

- Ella Booth, Chair
- Joe Finkbonner, co-Vice Chair
- Tricia Tillman, co-Vice Chair
- Michelle Berlin
- Ed Blackburn
- Bruce Bliatout
- John Duke
- Scott Ekblad
- Honora Englander
- Yves Lefranc
- Holden Leung
- Jackie Mercer
- Maria Michalczyk
- Melinda Muller
- Laurie Powers
- Noelle Wiggins

Staff:
- Heidi Allen
- Nathan Hierlmaier
The Charge

- Develop multicultural strategies
- Policy recommendations for reducing health care disparities
Figure 1: Steps to Achieving Health Equity

- Establish public reporting of health disparities:
- Collecting data with cultural sensitivity and accuracy

- Quality of Care: Monitoring and Assessing Patient Views of Care

- Person-centered primary medical home model with community coordination and collaboration

- Diversity in the workforce that reflects diversity in the community:
- Training culturally-sensitive providers:
- Language Access
- Personal Incentives

- The Clinic within the Community

- Building Relationships: Provider-Patient

- Access: Getting in the Door.

- Social Determinants of Health: Health Outside of the Delivery System

- Universal eligibility:
- Targeted outreach & enrollment within vulnerable communities:
- Benefit packages that support health

- Public health and community-based strategies to population wellness:
- Community Health Worker models

Addressing Barriers to Health Equity at the Community Level

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Focus Areas

• Preventing Health Disparities before they Occur

• Reducing Barriers to Health Care

• Improving the Quality of Care
RECOMMENDATIONS
Preventing Disparities

• Population-Based Approaches

• Strengthen the Relationship between Providers and Culturally Specific Community-Based Organizations (CBOs)

• Incentives for Healthy Personal Decision-Making
Reducing Barriers to Health Care

- Universal Eligibility
- Citizenship Documentation Barriers
- Targeted and Aggressive Outreach
- Cost-Sharing
Improving the Quality of Care

- Integrated Health Home
- Benefit Package
- Language Access
- Workforce
- Data Collection
- Quality Initiatives
Woe is me!!
There are two primary choices in life: to accept conditions as they exist, or accept the responsibility for changing them.--Dr. Denis Waitley
Thank you!

• Contact Information

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Resources


• An Ethical Force Program™ Consensus Report: Improving Communication—Improving Care How health care organizations can ensure effective, patient-centered communication with people from diverse populations. American Medical Association, 2006. [Link](http://www.ama-assn.org/ama1/pub/upload/mm/369/ef_imp_comm.pdf)

“What’s unethical about health disparities?”

Part Two

Tina Castanãres, MD
April 17, 2009
Three specific ways to reduce disparities and eliminate inequities

• Public Health

• Health Care Homes / Community Health Centers

• Community Health Workers
Public Health

• Promotes wellness with upstream health protection

• Doesn’t play the “personal responsibility” blame game

• Reduces demand for health care (overall spending, workforce, infrastructure)

• Raises all boats at once: truly equitable because population- and community-wide
Examples of Public Health

• Promoting healthy “built environments”

• Establishing and protecting standards for
  * food
  * water
  * air
  * housing and workplaces
  * safety (e.g. seat belts)
More examples of Public Health

• Promoting and supporting good practices, e.g.
  • Breastfeeding
  • Not smoking
  • Hygiene

• Anticipating and mitigating natural and manmade disasters

• Identifying, containing and reversing epidemics

• Preventing chronic diseases
Public Health: the hero of health improvement & protection

Improvements in our health are due far more to Public Health than to medical care.

“In the last 100 years, U.S. public health as increased life expectancy by 30 years through vaccinations, control of infectious disease, fluoridated drinking water and many other activities.”

(US CDCP)
Major impacts to our health

LACK OF PHYSICAL ACTIVITY, POOR NUTRITION & TOBACCO USE

“...In the past 3 decades, the health of Americans has changed dramatically. Adult obesity rates have doubled since 1980, and childhood obesity rates have tripled. Two-thirds of adults are either overweight or obese. The childhood obesity epidemic is putting today’s youth on course to possibly be the first generation to live shorter, less healthy lives than their parents. In addition, after years of declines, smoking rates have leveled off, with 21 percent of adults and 20 percent of high school students continuing to smoke. →
Major impacts to our health

→ Right now, more than half of Americans live with one or more chronic disease, such as heart disease, stroke, diabetes, or cancer. One in 4 Americans has heart disease; one in 3 has high blood pressure. Twenty-four million Americans have type 2 diabetes, and another 54 million are pre-diabetic. An estimated 2 million adolescents have pre-diabetes. The risks of developing heart disease, stroke, and kidney disease are exponentially higher if a person is both obese and a smoker.”

Trust for America’s Health

www.healthyamericans.org
Impoverished people are at higher risk

• Targeted tobacco advertising
• Barriers to physical activity in schools, workplaces, neighborhoods
• Food subsidies making fast and processed foods cheaper
• Environmental contaminants
• Lack of access to fresh foods
• Crowding and substandard housing
• Many other well-documented factors
Imagine if we lived in a region....

•....where robust investment in Public Health showed national leadership

Prevention for a Healthier America:
*Investments in Disease Prevention Yield Significant Savings, Stronger Communities*

**JULY 2008**
Imagine if we lived in a region....

•....where prevention and preparedness were viewed as the linchpins to health and health equity

Blueprint for a Healthier America:
October 2008
Imagine if we lived in a region....

•....where our discussions about “health care reform,” “resource allocation,” disparities and inequities in health all focused first on Public Health

•It would be transformative.
Isn’t it our ethical obligation to support Public Health?
Health Care Homes

• Offer integrated services, holistic perspective
• Focus on prevention and primary care
• May incorporate Public Health initiatives/activities, often community-based health promotion and chronic disease prevention
• Our safety net clinics (FQHCs and others) are generally the best national examples
Health Care Homes

Lend themselves to serving minority, marginalized, & underserved populations… hence reduce inequities while promoting access to health care:

* **language/culture**
* **literacy**
* **transportation**
* **social services**
* “one-stop shopping”
* **more**
In contrast, today:

- The delivery system is fragmented
- Specialty care is rewarded
- Delayed care is rewarded
- Care of preventable complications is rewarded
- Heroic care and rescues are rewarded
Isn’t it our ethical obligation to support Health Care Homes?
Community Health Workers

• A missing link

• Bridging Public Health and Health Care to reduce health inequities & increase access to health care
Community Health Workers

- Also known in Spanish as *promotoras or promotores de salud* (health promoters)
- Utilized all over the world
- Utilized increasingly in primary care in the US, esp. in minority communities and with special populations
- But still greatly *underutilized* in most medical, dental, and mental health care
What is a CHW?

• Lay people from the “target” community
• Definitions and descriptions vary
• Scope of practice varies
• No single or standard definition
• Some roles and skill areas are widely accepted, however… ➔
Seven roles (what CHWS do):

- Cultural mediation between communities & providers
- Informal counseling & social support
- Providing culturally appropriate health education
- Advocating for individuals & community
- Ensuring people get the services they need
- Building individual & community capacity
- Providing direct services
Direct clinical services by CHWs

• Care coordination
• Case management
• Population-based preventive initiatives
• Chronic disease management
People from the target community...

...will always give & convey the most reliable and useful information

if they are

- Well chosen
- Well trained
- Well supervised
- Well supported
- Well respected
- Well compensated
CHWs build individual & community capacity

• CHWs can be closely connected with
  natural community partners:
    * hospitals * community clinics *
    * social service organizations *
    * schools * churches * media * local health
departments * hospices *
    * youth groups * residential facilities *

• CHWs can be community-based, clinic-based, or both
CHWs build individual & community capacity

• CHWs are a natural fit with integrated Health Homes
• CHWs are a natural fit with Public Health
• CHWs demonstrably reduce and prevent inequities
Isn’t it our ethical obligation to support greater utilization of CHWs?
Let’s support the right things to eliminate inequities – notably,

• Public Health
• Health Care Homes / Community Health Centers
• Community Health Workers
for participating. I welcome your feedback!

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