Why Health Equity

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Notes. This document contains racist language used in historical settings for context. Some readers may find this language upsetting.

Introduction

Oregon's population is growing and becoming more diverse. OHSU Health must remain responsive to the communities it serves by launching efforts to establish health equity for all Oregonians which address historical and ongoing health inequities.

The Oregon population grew from 3.8 to 4.2 million people between 2010 and 2020.[1] Over this period, the counties where OHSU facilities are primarily located (Multnomah and Washington counties) reported an increase in the racial and ethnic diversity of their populations.[2,3] In 2020, 34.3% and 35.3% of Oregonians identified as nonwhite in Multnomah and Washington counties respectively, according to U.S. Census data, up from 27.9% and 24%, respectively, in 2010.[2,3] Local communities identifying as Asian, mixed race–non-Hispanic, and Hispanic or Latino saw the largest growth during that time.[2,3] According to USAFACTS, Oregon's white population dropped 4.5% from 2010 to 2021; comprising 78.5% of the population in 2010 to 74% in 2021.[4] Oregon's population is also getting older; residents aged 65 years and older increased by almost 47% between 2010 to 2021, from 537,000 to over 788,000.[5]

In Multnomah and Washington counties, Black, Indigenous, Hispanic, Asian, and other families of color were more likely to be living below the federal poverty level in 2020.[6,7] For instance, 29.6% of Black families in Multnomah County were living below the poverty line in 2020, compared with 6.1% of white families, a 131% difference.[6] Services and resources that help people achieve optimal health and stay healthy are limited for those living in poverty. These include access to nutritious food and beverages, exercise equipment, resources to stop smoking, and living in a home (rented or owned) free from environmental toxins.[8]

Inequities are rooted in imbalances in both power and access to resources, and stand in the way of health, optimal care, and affordability. Intersectionality—the notion that our social identities (e.g., race, ethnicity, gender identities, disabilities) reflect multiple interlocking systems of power at both the sociopolitical and interpersonal levels—demonstrates the importance of examining and addressing health inequities across multiple interdependent social identities. An intersectional approach reminds us that in a state that is becoming increasingly diverse and older, it is important to consider how intersectional identities (e.g., older Black women) may be disproportionately harmed.

To provide optimal care, access, and health for all communities in Oregon, OHSU Health must work to address the root causes of both health disparities and health care disparities, particularly the racism that influences them. Health disparities are preventable differences in illness, violence, injury, disability, or mortality experienced by one group relative to another. Health care disparities are experienced differently among groups within the system of care, including insurance coverage, access to and use of care, and quality of care.

This document outlines eight key reasons why OHSU Health must work in partnership with communities who have experienced structural oppression (e.g., racism, classism, homophobia, transphobia) to advance health justice, as well as to equitably distribute power and resources to achieve optimal health for all Oregonians.

1. Structural racism causes trauma and inequity

Racism permeates every facet of our society. It is frequently associated with the actions of a single perpetrator, such as in interpersonal interactions in health care settings. But racism also exists in the institutions and structures of our health care system and drives inequities in health and well-being. Institutional racism occurs at the organizational level, most commonly in the form of unconscious bias.[9] For instance, Black patients are significantly less likely to be prescribed pain medication and they generally receive lower doses of it.[10] This may be due to a pervasive clinician bias that Black patients experience less pain than white patients.[11]

Structural racism refers to historical and/or ongoing laws, rules, or policies in a society that results in unfair and harmful treatment of individuals based on race or ethnicity.[12] For example, the National Labor Relations Act of 1935, also known as the Wagner Act, allowed unions to negotiate for higher wages and improved benefits including health insurance, but domestic and agricultural workers were excluded from the law, and labor unions could discriminate against Black, Indigenous, Hispanic, Asian and other minoritized groups.[13] More than 85 years later, due to the enduring impacts of these laws on the culture and practices in our country, Black, Hispanic/Latino, and Native American community members are still more likely to lack health insurance and regular access to quality primary care, compared to the white population.[14]

Oregon has a notable history of being unwelcoming to Black, Indigenous, Asian and other historically underserved communities,[*] especially Black individuals.[15] Black people were banned from living in Oregon in 1844, and such laws were not repealed until 1927.[15] Interracial marriage prohibitions and equal access restrictions to public facilities and services in Oregon were in place through the 1950s.[15] Historical racial references, such as "negroes," and "mulattoes" were not removed from the state's constitution until 2002.[16] Only very recently (in 2022) through Ballot Measure 112, did Oregon voters finally amend the state constitution to remove language allowing slavery and involuntary servitude as punishment for crime.

Like many U.S. cities, Portland and several other Oregon cities and towns have longstanding histories of racist and discriminatory housing and land use practices. Racist practices such as exclusionary zoning, racially restrictive covenants, or "redlining" played pivotal roles in shaping Oregon, and in creating and exacerbating inequities along lines of race and class. Not until 2015 did the Affirmatively Furthering Fair Housing Rule (AFFH), a provision of the Fair Housing Act, "set out a framework for local governments, States, and public housing agencies to take meaningful actions to overcome historic patterns of segregation, promote fair housing choice, and foster inclusive communities that are free from discrimination."[17] Jurisdictions receiving federal funding are obligated to not only implement fair housing

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[*] Consistent with OHSU's Inclusive Language Guide, this document uses "Black, Indigenous, Hispanic, Asian and other historically underserved communities" as a broad term, and uses of more specific descriptors when those are known or relevant. When using or citing a particular reference, this document uses the terms used in the source document, as cited.

policies but to also address past harms of segregation and racist policies that have been in place for generations.

The multigenerational impacts of structural racism in Oregon persist in various ways. In 2011, more than 35% of women of color had no regular health care clinician, compared with 18% of white women.[15] The life expectancy for Black or American Indian/Alaska Native (AI/AN) Oregonians was 2 years shorter than for white Oregonians.[15]

There were 307 white people imprisoned per 100,000 people in April 2020, according to Oregon state prison data.[18] For Black individuals, the rate is 3.7 times higher at 1,126 per 100,000 people.[18] Black Oregonians were 3.1 times more likely to have COVID-19-associated hospitalizations than their white counterparts.[19] In Portland, individuals of color are more likely to live in communities with poorer air quality, which may lead to disproportionately impaired respiratory systems.[20] Black Oregonians are also nearly twice as likely to die once becoming unhoused compared to white individuals.[21]

Such racial inequities cause emotional distress and trauma, and can have lasting repercussions, including fear and mistrust of the health system and providers.[22] There is a growing base of evidence demonstrating the negative psychological and physical impacts of structural racism, and the cumulative trauma it builds and transmits across generations.[23-26] To aid in understanding the impact of structural racism on health, Hankerson and colleagues developed a conceptual model, focused on mental health, about the relationships among structural racism, cumulative trauma, and the transmission of depression across generations (Figure 1).[27]

Figure 1. Relationship of structural and interpersonal racism, cumulative trauma, and the intergenerational transmission of depression[27]
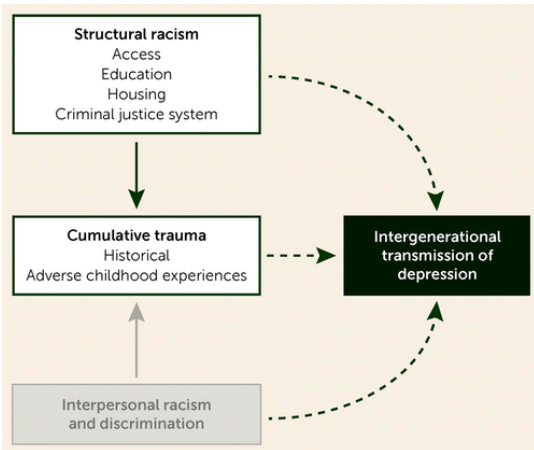
Source: The American Psychiatric Association.[27]

2. Health inequities are driven by social and structural factors

As OHSU seeks to provide excellent care and improve the health of all Oregonians, there is a limitation on what can be accomplished by merely waiting for people to get sick or access the health system. It is more effective and efficient (in terms of both human and cost outcomes) to partner with communities in preventing and addressing underlying causes. These causes combine with structural racism to manifest as social risk factors (SRFs).

Historically underserved communities experience poorer outcomes because they are systematically exposed to higher levels of SRFs. SRFs, also sometimes called social determinants of health, are conditions in the environment (such as education, income, access to nutritious food, and safe housing) which directly impact health and quality-of-life outcomes.[28,29] For instance, one of the reasons Black, Indigenous, Hispanic, Asian, and other historically underserved communities were more likely to be infected by COVID-19 was due to systemic influences causing these communities to experience higher rates of SRFs, so they were less able to isolate during state-mandated lockdowns.[30] Folks in these communities are more likely to live in crowded conditions, live in multigenerational households, and hold jobs that cannot be performed remotely.[30] Figure 2 illustrates common SRFs that disproportionately impact historically underserved communities.

Figure 2. Common SRFs disproportionately affecting underserved communities[31]

Figure source: Centers for Disease Control and Prevention.[31]
Abbreviation: SRF (social risk factor).

Black and Hispanic community members in the U.S. are less likely than white people to own traditional computers or have high-speed internet at home.[32] This disparity in access to high-speed internet has had a practical impact on care within Oregon. A 2021 journal article found that non-English speakers and Black patients in Oregon relied more on telephone than video visits as more clinicians and hospitals offered virtual medical visits for care.[33] The researchers found comparative lack of access to two-way video exacerbates disparities in the quality of care received.[33] The researchers believe ambulatory telehealth via video may offer a partial physical exam, nonverbal communication, and a stronger patient-provider relationship, which phone-only visits do not provide.[33]

Health care systems have increasingly been relying on partnerships with community organizations to address SRFs.[34] Examples of partnerships addressing SRFs include monetary investments in housing assistance programs, partnerships with private rideshare programs to provide subsidized or free transportation to health care appointments, and expanding access to healthy foods for patients via meal delivery programs or additional funding to food pantries.[35] Hospitals may seek out partnerships with agencies and organizations allowing them to address community health issues outside of their traditional expertise of providing health care services.[35] Hospital administrators reported that social needs referrals

to community partners were ideal, as it placed limited burden on care teams while also ensuring patients have their SRFs met.[36] However, the success of efforts to address SRFs depends, at least in part, on addressing the inequitable distribution of social resources. Oregon is beginning to take some steps in this direction. In 2022, the Centers for Medicare & Medicaid Services approved a new five-year Oregon Health Plan Medicaid demonstration waiver.[37] This waiver allows for the provision of services to address "health-related social needs" for Medicaid beneficiaries, including nutrition and transitional housing supports.[37] These newly approved benefits are set to be phased in beginning in 2024 and 2025.[37] The waiver paves the way for innovations in connecting health systems, communities, and community providers to meet health-related social needs.[37] Connect Oregon is a network of health and social service providers (including OHSU) that was formed to enable seamless referrals to address social needs and improve health across communities.

3. Historically underserved communities are less likely to have health insurance

Historically underserved communities are more likely to be without health insurance, or rely on public insurance programs. Providing care for individuals without insurance, who rely on public insurance programs, and who are underinsured, results in higher costs within health care systems.

Black and Hispanic adults have historically reported much higher uninsured rates than white adults, in part because they are much less likely to receive coverage through their jobs.[38] More than 57% of adults and 67% of children enrolled in Medicaid identify as AI/AN, Asian American and Pacific Islander (AAPI), Black, Hispanic, or multiracial.[39] Over 20% of Medicare fee-for-service (FFS) enrollees identify as individuals holding minoritized racial identities.[40] The Kaiser Family Foundation has highlighted disparities in insurance coverage by race and ethnicity (Figure 3).

Figure 3. Disparities in health insurance coverage by race and ethnicity
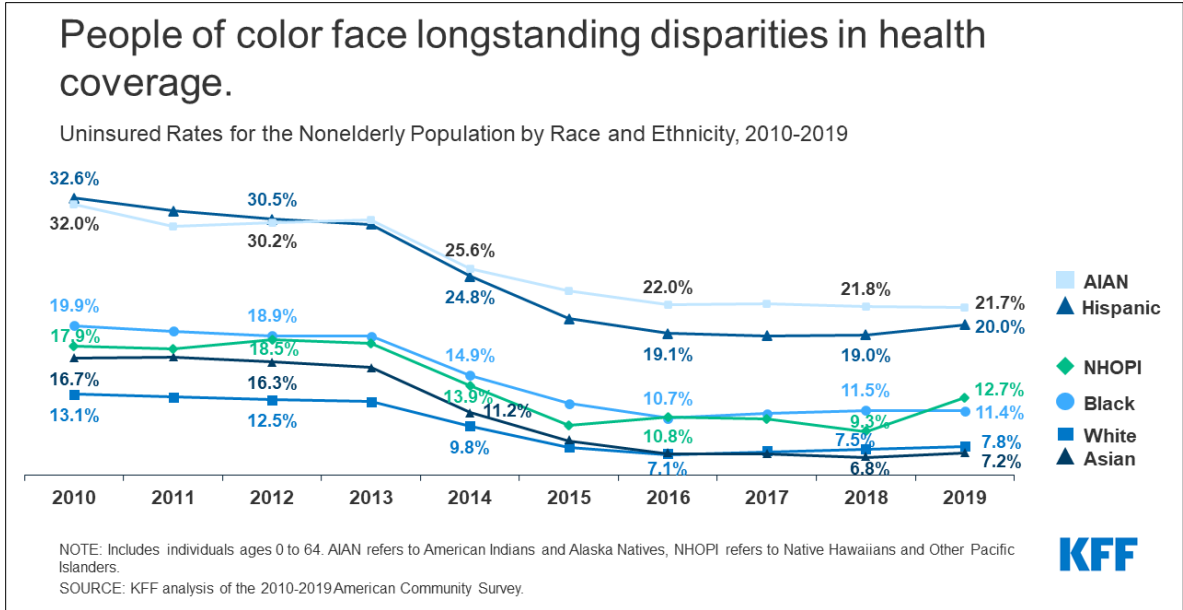

Figure source: Kaiser Family Foundation.
Abbreviations: AIAN: American Indians and Alaska Natives; NHOPI: Native Hawaiians and other Pacific Islanders.

Due to their inability to receive regular outpatient care, people without health insurance are more likely to be hospitalized for avoidable health problems and to experience declining health.[41] Uninsured individuals receive fewer diagnostic and therapeutic services when hospitalized, and they also have a higher mortality rate.[41]

In addition, patient care revenues and profits per patient at hospitals with a higher portion of patients of color are less than the revenues and profits received by hospitals with a higher proportion of white patients, in part due to lower insurance rates.[25,26] A primary source of revenue for most hospitals in the U.S. is Medicare payments, which are increasingly not covering the full cost of an individual's hospitalization.[10,27] In 2018, the aggregate Medicare margin was −9.3% for inpatient hospitals, according to the Medicare Payment Advisory Commission.[10] As Medicare payments have not kept up with the cost of services, the average inpatient hospital Medicare margin has been negative since 2008.[10] According to the American Hospital Associations, in 2019 hospitals were compensated only 87 cents for each dollar they spent treating Medicare patients and 90 cents for every dollar they spent treating Medicaid patients.[11] The group estimates the total Medicare and Medicaid shortfall reached $75.8 billion right before the COVID-19 pandemic hit the U.S. in the first quarter of 2020.[11]

4. There is inequitable access to the right care at the right time

Structural racism, perpetuated by the health care system, has led to inequitable access and care, and has created mistrust among those using the system.

According to a 2021 research article in *JAMA*, Black Americans spent 26% less per person on outpatient care (where the majority of preventive health care occurs) but 12% more per person on emergency department care (after health has deteriorated to urgent levels).[42] Non-Hispanic white Americans accounted for 15% more spending per person on outpatient care than average, which the researchers attributed to better access to routine and preventive care.[42] The researchers noted this finding highlighted unequal access to preventative care across the U.S. health care system.[42]

Black, Hispanic/Latina, and AI/AN individuals may avoid preventive screenings due to mistreatment in health care settings.[43] Black, Indigenous, Hispanic/Latina, Asian, and other historically underserved women (especially Black women) experience longer wait times, decreased communication from clinicians, and inconsistencies in treatment and recommendations, according to a report released by the U.S. Commission on Civil Rights in September 2021.[43] A separate study by researchers at the University of California, San Francisco found that women of color are often made to feel judged or disrespected during a prenatal visit, leading them to forgo additional visits.[44] In this way, the health care system may contribute to the increased risk of worse birth outcomes for women of color.[44]

Black men have reported that their mistrust of clinicians and hospitals spikes when they do not have a patient-centered clinician interaction.[45] Hammond and other researchers define patient-centered interactions as medical appointments with mutual, supportive, and responsive communication between clinician and patient.[45-48] Despite this expectation, fewer Black patients than white patients report having had these interactions with clinicians.[49] As a result, Black men report skipping preventative care, which is one mechanism by which the health care system may contribute to poorer health outcomes.[50] Being treated unjustly by health systems exacerbates the problem. The Kaiser Family Foundation has outlined the likelihood of Black and Hispanic adults trusting a variety of institutions and groups, including health care, is lower than the likelihood of white adults trusting them (Figure 4).

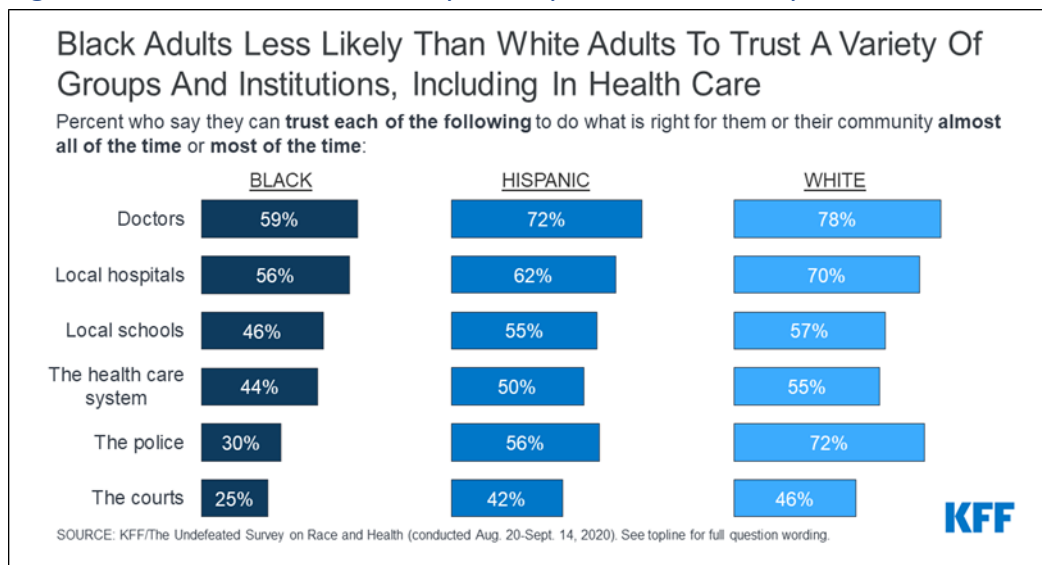Figure 4. Mistrust of health care system by race and ethnicity[51]

Black Adults Less Likely Than White Adults To Trust A Variety Of Groups And Institutions, Including In Health Care

Percent who say they can **trust each of the following** to do what is right for them or their community **almost all of the time** or **most of the time**:

	BLACK	HISPANIC	WHITE
Doctors	59%	72%	78%
Local hospitals	56%	62%	70%
Local schools	46%	55%	57%
The health care system	44%	50%	55%
The police	30%	56%	72%
The courts	25%	42%	46%

SOURCE: KFF/The Undefeated Survey on Race and Health (conducted Aug. 20-Sept. 14, 2020). See topline for full question wording.

KFF

Image Source: Kaiser Family Foundation.[51]

5. Historically underserved communities have higher rates of illness and worse outcomes

Historically underserved communities experience higher rates of illness and death, and worse overall health outcomes and quality of life. Although the impacts of health inequities disproportionately harm structurally oppressed groups, the presence of inequity impacts us all, through higher health care costs and reduced productivity for our state, our community, and at OHSU.

In a 2019 journal article, researchers noted that Hispanic and Asian patients who requested emergency medical services in Oregon for traumatic injuries were less likely to have their pain assessed, and patients of all minoritized racial and ethnic groups were less likely to be treated with pain medications when compared with white patients.[52]

The health outcomes for individuals holding identities as Black, Indigenous, Hispanic, Asian and other historically underserved communities cultural identities are generally worse than those of the white population.[20] The COVID-19 pandemic further highlighted and exacerbated health inequities among communities holding minoritized racial and cultural identities.[21] COVID-19 rates in the US were higher among Black, Hispanic, and American Indian community members.[21] As a result of a higher prevalence of chronic medical comorbidities (such as hypertension or diabetes), historically underserved communities are more likely to be hospitalized once infected.[21] These factors exacerbate the severity of COVID-19 infections in these populations.[21] The Kaiser Family Foundation has outlined differing health outcomes based on race and ethnicity, including infant mortality, pregnancy-related deaths, prevalence of chronic conditions, and overall physical and mental health status (Figure 5).
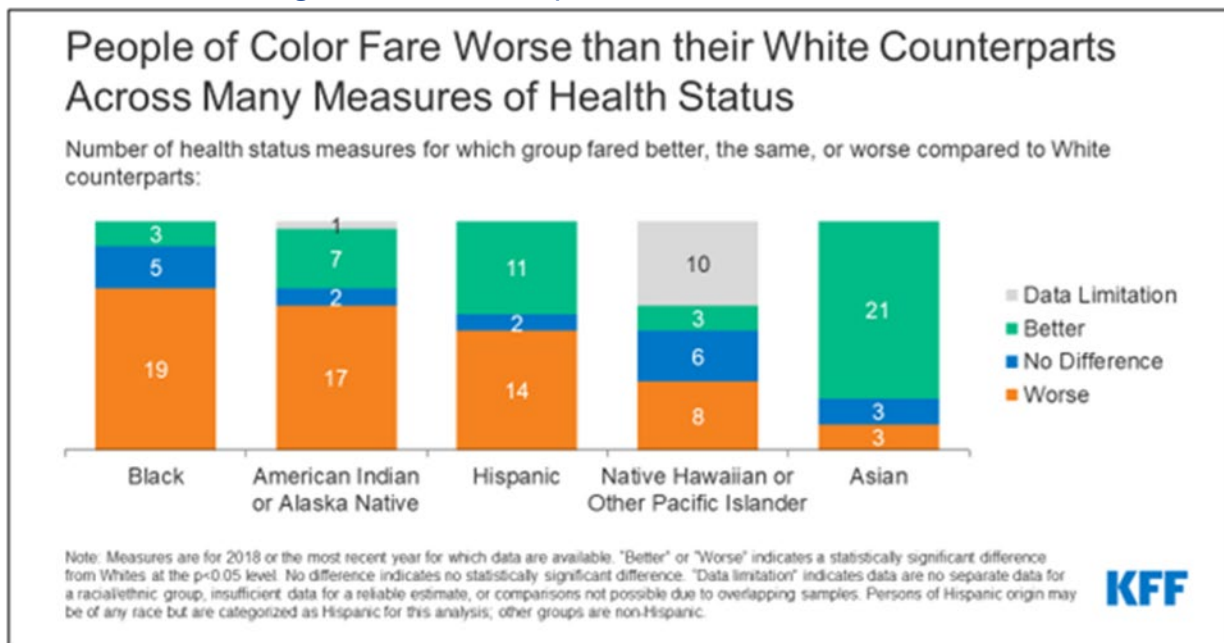
Figure 5. Health inequities across ethnicities[53]

People of Color Fare Worse than their White Counterparts Across Many Measures of Health Status

Number of health status measures for which group fared better, the same, or worse compared to White counterparts:

Note: Measures are for 2018 or the most recent year for which data are available. "Better" or "Worse" indicates a statistically significant difference from Whites at the p<0.05 level. No difference indicates no statistically significant difference. "Data limitation" indicates data are no separate data for a racial/ethnic group, insufficient data for a reliable estimate, or comparisons not possible due to overlapping samples. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.

KFF

Figure source: Kaiser Family Foundation.[53]

A 2019 study found that a clinical algorithm used by many hospitals to direct patient care was racially biased, and that Black patients had to be deemed much sicker than white patients to be recommended for the same level of care.[54] The clinical algorithm had been developed using past health care spending as a proxy for need, reflecting a history in which Black patients had less to spend on their health care compared to white patients, due to longstanding wealth and income disparities.[54] While this algorithm's bias was eventually detected and corrected, it raises an important question about whether, and how, other clinical algorithms could be discriminatory, particularly with the lack of validation and oversight of such tools.

In addition to inequitable care experiences, Valtis and colleagues found a higher likelihood of hospital security being called on Black patients and Black hospital visitors, compared with their white counterparts.[55] A separate analysis by Sun and colleagues found that Black patients are almost three times more likely than white patients to be described as "aggressive" and "noncompliant" in their electronic health records.[22]

There are local implications to these various studies. A 2020 study in the *American Journal of Preventive Medicine* found that low-income individuals on the Oregon Health Plan (Oregon's Medicaid program) were less likely to receive colorectal cancer screenings than those with commercial insurance, which could lead to later diagnosis of the disease and ultimately higher medical costs.[56] According to the National Cancer Institute, the average cost of medical care and drugs in the year following a cancer diagnosis can be in the tens of thousands to over $1 million, depending on treatment.[57]

6. Addressing health inequities is a cost-effective path toward excellence in care

Health inequities and biases frequently result in unnecessary health care expenditures.[58] Evidence suggests that health care spending is higher among historically underserved communities and low-income individuals because they experience delays in treatment, lack of access to proper preventive care, and missed diagnoses.[58] For instance, the prevalence of diabetes among Black adults is 60% higher than in white adults; diabetes-related complications are also two to three times more likely to occur.[58] There is also a strong correlation between racial inequity and a late diagnosis and comorbidities.[58] Health care disparities result in an unnecessary $15 billion in diabetes spending nationally, according to an analysis by actuaries at the consulting company Deloitte.[58]

Addressing health inequities should be a foundational aspect of broader systems efforts to decrease unnecessary health care costs. Deloitte estimates that health inequities result in an annual health care spending of approximately $320 billion, signaling an unsustainable effect on the U.S. health care system, particularly when population changes are accounted for.[58] In 2040, this figure could reach $1 trillion or more in the U.S. if left unaddressed (Figure 6).[58]
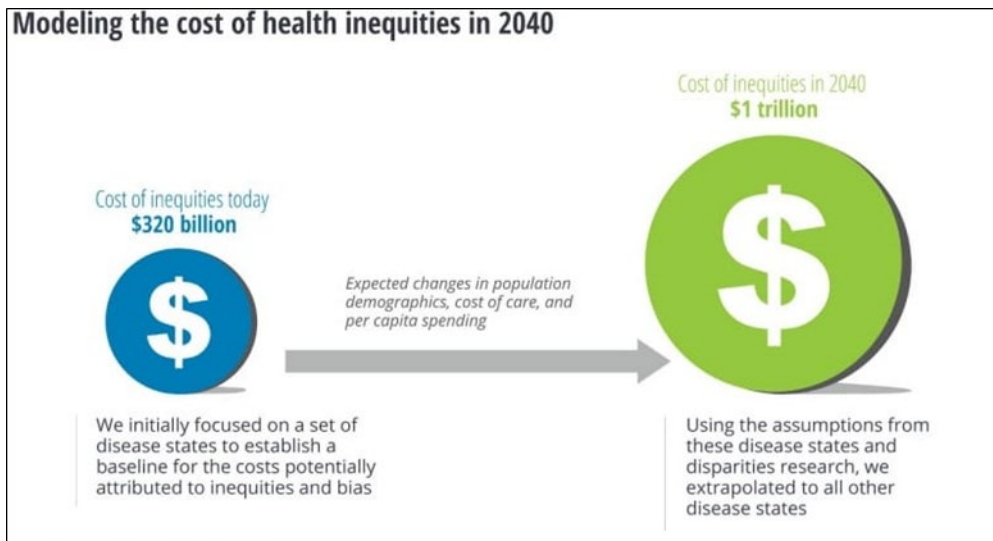
Figure 6. Financial impact of addressing health inequities[58]

Modeling the cost of health inequities in 2040

Cost of inequities today
$320 billion

Expected changes in population demographics, cost of care, and per capita spending

Cost of inequities in 2040
$1 trillion

We initially focused on a set of disease states to establish a baseline for the costs potentially attributed to inequities and bias

Using the assumptions from these disease states and disparities research, we extrapolated to all other disease states

Image source: Deloitte.[58]

7. Empowering communities most impacted by health inequity to co-create health care solutions will improve outcomes and ensure sustainability

Social risk factors (e.g., food insecurity, housing instability, low-income status) contribute significantly to health outcomes. It is increasingly understood that exposure to SRFs is a function of power and opportunity; increased access to resources mitigates exposure to SRFs, whereas decreased resources increases one's exposure to SRFs. Therefore, public health and health equity experts have increasingly called lack of power a determinant of health inequity and recommended building power as an intervention against it.[59,60]

For this reason, health care systems are increasingly turning toward community partnership strategies to establish and maintain trust, codesign health care programs, and to redistribute and build power with systemically harmed communities. Effective community partnerships—ones where power and resources are shared—lead to more effective programs, enhanced communication between health systems and communities, and sustained collaborations.[61] Just as importantly, evidence shows that the process of building power with systemically harmed communities serves not only to help health care systems in delivering more effective programs, but it also demonstrates that increasing community power also leads to better prevention of disease,[62] decreased disease severity,[63] more equitable delivery of care,[64] and enhanced neighborhood conditions for systemically harmed groups.[65,66] Building power with communities must be within the purview of any health care system looking to engage meaningfully in health equity work.

It is critical to note, however, that community partnerships as a lone tactic is insufficient to advance health equity. To realize the fullest potential of community partnerships as a means to advance health justice, health care systems must move on from involving community partners in transactional ways that demonstrate little-to-no power sharing, to fostering trust, transparency, and accountability through sharing power and decision making. Environmental scans of community partnership work show that the vast majority of these initiatives tend to confine community members as simply being present in decision-making spaces without formal authority, or to providing feedback on proposals and designs that may or may not be implemented by the health care system.[67]

Transformational efforts move beyond these transactional relationships by sharing and building power with communities. At the bedrock of power sharing with communities is the foundational belief that "those most affected by health inequity should take the lead in crafting and prioritizing the solutions."[59] Through its funding of community engagement initiatives to advance health equity, the Robert Wood Johnson Foundation has identified effective power-sharing strategies, including compensating community partners for their lived expertise; co-creating shared norms, community agreements, and decision-making structures that narrow power differentials; and proactively developing the leadership capacity of community partners.[68] The Robert Wood Johnson Foundation has outlined the correlation between the level of impact leading to transformation, and shared power (Figure 7). This approach to community partnerships represents a significant departure from the processes and practices typically seen within health care workflows and collaborations, and requires deep self-reflection and reliance on unique expertise to execute effectively while minimizing—if not eliminating—harm to community partners.

8. Health equity and justice is everyone's responsibility
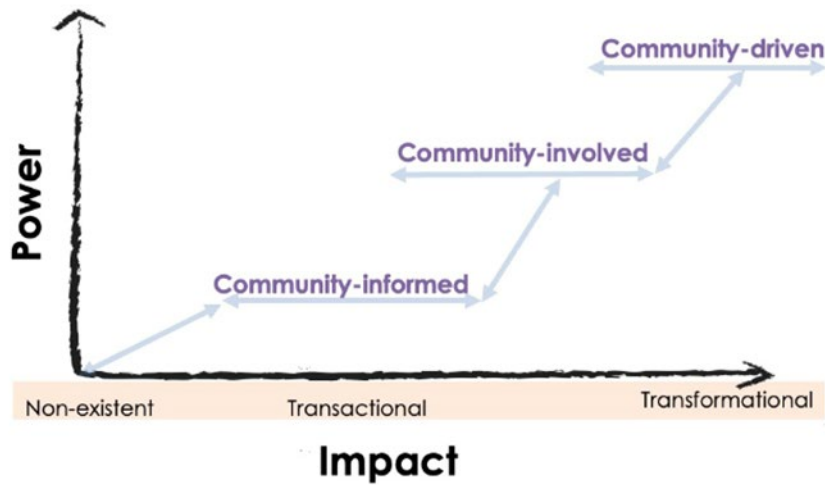
The concept of equal opportunity is embedded in the founding doctrines of our country. At the same time, bias-based inequities have also been engrained in the policies, practices, laws, and norms of our nation, state, and health care institutions, putting equal opportunity out of reach for many individuals and communities, especially those with identities from Black, Indigenous, Hispanic, Asian and other historically underserved communities.

The advancement of optimal health for all requires equity and health justice to be systematically centered. Equity must be woven into the fabric of new policies, processes and operations from the beginning rather than in a post hoc review. It will require us to anticipate the impact and mitigate inequities in real-time while simultaneously identifying and rectifying historical injustices. It will require us to create innovative opportunities for people and communities who historically have been (and continue to be) underserved and adversely affected by inequality, to thrive. We all benefit from equal opportunity, and it is the responsibility of each of us to create it. Individually and collectively, we have the responsibility to ensure OHSU Health exemplifies:

- Equity: Consistently and systematically giving fair, just, and impartial treatment to all individuals according to their circumstances, with special attention paid to individuals belonging to underserved communities that have been denied such treatment, or individuals who have been adversely impacted by inequality.[69]
- Justice: Using policies, processes, and individual and collective action to address and eliminate disparities, and to establish long-term, equitable, and sustainable practices going forward.[70]

As part of a self-study gap assessment performed in conjunction with the Washington State Health equity collaborative, OHSU generated a maturity model to measure its progress towards becoming an anti-racist institution. The domains included governance, social needs and community outreach, data

collection, data analysis, goals, staff skills and attitudes, culturally-humble care delivery, and a diverse workforce. This document provided an early framework to view campus wide activities.

In December of 2021, the findings of the Covington report provided a clear mandate for needed change at OHSU. OHSU leaders were resolute in stating that there is work to do to "overcome the past and change the future" so that OHSU can be a place "where everyone can thrive." Dr. Jacobs and the board have acted swiftly to make sure the report led to lasting change. By launching a range of efforts to build an antiracist institution that lifts the entire community, OHSU seeks to build a culture where all feel welcome and safe.

Establishing a "health equity unit" within OHSU Health is a transformational demonstration of the new identity OHSU seeks to manifest. OHSU leadership has committed to new standards and expectations for what culture, climate, diversity, equity, belonging, inclusion, and antiracism look like at the institution. OHSU has the opportunity to be an exemplar among academic institutions nationwide. Achieving culture change, as well as centering new standards and expectations, will require the efforts of each of us, and the benefits will be shared by all of us.

Conclusion

There is a great and pressing need for OHSU to center health equity within its policies and practices. Historically underserved communities have long faced disparities in health and health care, driven in large part by interpersonal, institutional, and structural racism. These disparities have been amplified during the COVID-19 pandemic. Social and economic inequalities are rooted in issues such as mistrust of medical professionals, lack of preventative care and screenings, types of insurance coverage, and social risk factors. In addition, the intersectionality among age, race, ethnicity, ability, sexual orientation, religion, documentation status, and other factors magnifies the injustice experienced by many and warrants focused attention. The central pillar of this work will be data. Our ability to make progress in establishing health equity and justice is contingent on gathering necessary data, enabling us to understand and measure our impact. Data that can be broken down and analyzed by key indicators of historical disparity and inequity (e.g., race, ethnicity, gender, disability, age) is essential. Disaggregated data offers more detailed statistical indicators of population health, as well as insight into who can and cannot access care, and whether historically underserved or underrepresented communities benefit from the care they receive. Equitable policies and care delivery also require data collection and analysis to understand the ways in which individuals who may belong to several underserved or underrepresented communities can experience compounded discrimination or disadvantage.

There is growing recognition of the important role of data as a tool in addressing historical disparities and rectifying structural racism. Data has the power to reveal, inform and hold accountable. Pursuant to Executive Order 13985 issued by President Biden in January 2021, an Equitable Data Working Group was established to make recommendations to improve efforts to "measure equity and capture the diversity of the American people." Leading from their suggestions, in April 2022, the Working Group recommended a vision for data:

"Equitable data are those that allow for rigorous assessment of the extent to which government programs and policies yield consistently fair, just, and impartial treatment of all individuals. Equitable data illuminate opportunities for targeted actions that will result in demonstrably improved outcomes for underserved communities."[71]

Equitable, disaggregated data will ensure that OHSU Health advances equity and justice, and support the antiracism efforts of OHSU at large.

Consistent with the culture change called for by leaders following the Covington Report, OHSU Health has the opportunity to take a leadership role in establishing health equity and justice for all in Oregon. OHSU Health should advance equity goals through a variety of tactics focused on delivering effective and equitable care, providing inclusive experience for all cared for by OHSU Health, and building collaborative efforts with community partners, actively including those with lived experience of oppression.

References

1.   US Census Commission. Quick facts Oregon. 2021; https://www.census.gov/quickfacts/OR. Accessed December 6, 2022.

2.   US Census Commission. Multnomah County racial data. 2021; https://data.census.gov/table?q=multnomah+county,+oregon&tid=DECENNIALPL2020.P2. Accessed December 6, 2022.

3.   US Census Commission. Washington County racial data. 2021; https://data.census.gov/table?q=Washington+County,+Oregon.

4.   American College of Obstetrics and Gynecology. Talking points: Extending Medicaid coverage for pregnant women beyond 60 days postpartum. 2022; https://www.acog.org/-/media/project/acog/acogorg/files/advocacy/talkingpoints-extending-medicaid-coverage-for-pregnant-women-beyond-60-days-postpartum.pdf.

5.   USA Facts. Our changing population: Oregon. 2021; https://usafacts.org/data/topics/people-society/population-and-demographics/our-changing-population/state/oregon. Accessed December 13, 2022.

6.   US Census Commission. Multnomah County poverty status in the past 12 months of families. 2021; https://data.census.gov/table?q=Multnomah+County,+Oregon+Income+and+Poverty&tid=ACSST5Y2020.S1702. Accessed December 6, 2022.

7.   US Census Commission. Washington County poverty status in the past 12 months. 2021; https://data.census.gov/table?q=Washington+County,+Oregon+and+Poverty&tid=ACSST5Y2020.S1701. Accessed December 6, 2022.

8.   Finkelstein DM, Harding JF, Paulsell D, English B, Hijjawi GR, Ng'andu J. Economic well-being and health: the role of income support programs in promoting health and advancing health equity. *Health Aff (Millwood)*. 2022;41(12):1700-1706. doi: 10.1377/hlthaff.2022.00846.

9.   Jones DD. Examining the Unconscious Racial Biases and Attitudes of Physicians, Nurses, and the Public: Implications for Future Health Care Education and Practice. *Health Equity*. 2022;6(1):375-381. doi: 10.1089/heq.2021.0141.

10.   Morales ME, Yong RJ. Racial and Ethnic Disparities in the Treatment of Chronic Pain. *Pain Medicine*. 2021;22(1):75-90. doi: 10.1093/pm/pnaa427.

11. Trawalter S. Black Americans are systematically under-treated for pain. Why? 2020; https://batten.virginia.edu/about/news/black-americans-are-systematically-under-treated-pain-why. Accessed December 9, 2022.

12. Churchwell K, Elkind MSV, Benjamin RM, et al. Call to Action: Structural Racism as a Fundamental Driver of Health Disparities: A Presidential Advisory From the American Heart Association. *Circulation.* 2020;142(24):e454-e468. doi: 10.1161/CIR.0000000000000936.

13. Solomon D, Maxwell C, Castro A. Systematic inequality and economic opportunity. 2019; https://www.americanprogress.org/article/systematic-inequality-economic-opportunity/. Accessed February 15, 2023.

14. Sohn H. Racial and ethnic disparities in health insurance coverage: dynamics of gaining and losing coverage over the life-course. *Popul Res Policy Rev.* 2017;36(2):181-201. doi: 10.1007/s11113-016-9416-y.

15. Coalition of Communities of Color. Communities of color in Multnomah County: an unsettling profile. 2014; https://www.coalitioncommunitiescolor.org/research-and-publications/cccunsettlingprofile#:~:text=Communities%20of%20Color%20in%20Multnomah%20County%3A%20An%20Unsettling%20Profile,-%240.00&text=This%20report%20centers%20the%20experiences,will%20be%20a%20tough%20read. Accessed December 21, 2022.

16. Ballotpedia. Oregon removes constitutional references to race, measure 14. 2002; https://ballotpedia.org/Oregon_Remove_Constitutional_References_to_Race,_Measure_14_(2002). Accessed December 21, 2022.

17. US Department of Housing and Urban Development. AFFH fact sheet: the duty to affirmatively further fair housing. 2019; https://www.hud.gov/sites/dfiles/FHEO/documents/AFFH-Fact-Sheet.pdf. Accessed January 9, 2023.

18. Jensen L. Black Oregonians are imprisoned at a rate almost four times that of white people. 2021; https://www.wweek.com/news/2021/05/05/black-oregonians-are-imprisoned-at-a-rate-almost-four-times-that-of-white-people/. Accessed December 21, 2022.

19. Authority OH. Oregon 1115 demonstration waiver. 2021; https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-Waiver-Application-Final.pdf. Accessed December 21, 2022.

20. Profita C. Study: more people of color live near Portland's biggest air polluters. 2020; https://www.opb.org/news/article/oregon-portland-study-people-of-color-polluted-neighborhoods-redlining-covid-19/. Accessed December 21, 2022.

21.   Oregon Health Authority. Domcile unknown data. 2022; https://visual-data.dhsoha.state.or.us/t/OHA/views/Oregonpreliminarydomicileunknowndeaths/Dashboard?%3Adisplay_count=n&%3Aembed=y&%3AisGuestRedirectFromVizportal=y&%3Aorigin=viz_share_link&%3AshowAppBanner=false&%3AshowVizHome=n. Accessed December 21, 2022.

22.   Sun M, Oliwa T, Peek ME, Tung EL. Negative patient descriptors: documenting racial bias in the electronic health record. *Health Aff (Millwood).* 2022;41(2):203-211. doi: 10.1377/hlthaff.2021.01423.

23.   Williams DR, Williams-Morris R. Racism and mental health: the African American experience. *Ethn Health.* 2000;5(3-4):243-268. doi: 10.1080/713667453.

24.   Williams DR, Mohammed SA. Discrimination and racial disparities in health: evidence and needed research. *J Behav Med.* 2009;32(1):20-47. doi: 10.1007/s10865-008-9185-0.

25.   Molina KM, James D. Discrimination, internalized racism, and depression: A comparative study of African American and Afro-Caribbean adults in the US. *Group Process Intergroup Relat.* 2016;19(4):439-461. doi: 10.1177/1368430216641304.

26.   Hudson DL, Neighbors HW, Geronimus AT, Jackson JS. Racial Discrimination, John Henryism, and Depression Among African Americans. *J Black Psychol.* 2016;42(3):221-243. doi: 10.1177/0095798414567757.

27.   Hankerson SH, Moise N, Wilson D, et al. The Intergenerational Impact of Structural Racism and Cumulative Trauma on Depression. *American Journal of Psychiatry.* 2022;179(6):434-440. doi: 10.1176/appi.ajp.21101000.

28.   Alderwick H, Gottlieb LM. Meanings and misunderstandings: a social determinants of health lexicon for health care systems. *Milbank Q.* 2019;97(2):407-419. doi: 10.1111/1468-0009.12390.

29.   Green K, Zook M. When talking about social determinants, precision matters. 2019; https://www.healthaffairs.org/do/10.1377/forefront.20191025.776011/. Accessed November 30, 2022.

30.   Lopez L, Hart L, Katz M. Racial and ethnic health disparities related to COVID-19. *JAMA.* 2021;325(8):719-720. doi: 10.1001/jama.2020.26443.

31.   Centers for Disease Control and Prevention. Social determinants of health. 2023; https://www.cdc.gov/publichealthgateway/sdoh/index.html. Accessed February 22, 2023.

32.   Atske S, Perrin A. Home broadband adoption, computer ownership vary by race, ethnicity in the US. 2021; https://www.pewresearch.org/fact-tank/2021/07/16/home-broadband-adoption-computer-ownership-vary-by-race-ethnicity-in-the-u-s/. Accessed February 22, 2023.

33. Sachs JW, Graven P, Gold JA, Kassakian SZ. Disparities in telephone and video telehealth engagement during the COVID-19 pandemic. *JAMIA Open.* 2021;4(3):ooab056. doi: 10.1093/jamiaopen/ooab056.

34. Puro N, Kelly RJ, Cendoma P. What is driving hospital-community partnerships to address social determinants of health? *Acad Manag Proceed.* 2022;2022(1):17606. doi: 10.5465/AMBPP.2022.17606abstract.

35. Puro N, Kelly RJ. Community social capital or health needs: What is driving hospital-community partnerships to address social determinants of health? *SSM - Population Health.* 2022;18:101129. doi: https://doi.org/10.1016/j.ssmph.2022.101129.

36. Beidler LB, Razon Na, Lang H, Fraze TK. "More than just giving them a piece of paper": Interviews with Primary Care on Social Needs Referrals to Community-Based Organizations. *J Gen Intern Med.* 2022;37(16):4160-4167. doi: 10.1007/s11606-022-07531-3.

37. Oregon Health Authority. What's changing in the 2022 – 2027 1115 demonstration waiver. 2022; https://www.oregon.gov/oha/HSD/Medicaid-Policy/Pages/Changes.aspx. Accessed January 31, 2023.

38. Baumgartner J, Collins S, Radley D. Racial and ethnic inequities in health care coverage and access, 2013–2019. 2021; https://www.commonwealthfund.org/publications/issue-briefs/2021/jun/racial-ethnic-inequities-health-care-coverage-access-2013-2019.

39. Medicaid and CHIP Payment and Access Commission. Medicaid's role in advancing health equity. 2022; https://www.macpac.gov/wp-content/uploads/2022/06/Chapter-6-Medicaids-Role-in-Advancing-Health-Equity.pdf. Accessed November 30, 2022.

40. Milliman. Comparing the demographics of enrollees in Medicare advantage and fee-for-service Medicare. 2020; https://bettermedicarealliance.org/wp-content/uploads/2020/10/Comparing-the-Demographics-of-Enrollees-in-Medicare-Advantage-and-Fee-for-Service-Medicare-202010141.pdf. Accessed November 30, 2022.

41. Tolbert J, Drake P, Damico A. Key facts about the uninsured population. 2022; https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/#:~:text=When%20they%20are%20hospitalized%2C%20uninsured,rates%20than%20those%20with%20insurance.&text=Research%20demonstrates%20that%20gaining%20health,effects%20of%20having%20been%20uninsured. Accessed December 21, 2022.

42. Dieleman JL, Chen C, Crosby SW, et al. US Health Care Spending by Race and Ethnicity, 2002-2016. *JAMA.* 2021;326(7):649-659. doi: 10.1001/jama.2021.9937.

43.   US Commission on Civil Rights. Racial disparities in maternal health. 2021; https://www.usccr.gov/files/2021/09-15-Racial-Disparities-in-Maternal-Health.pdf. Accessed November 30, 2022.

44.   Altman MR, Oseguera T, McLemore MR, Kantrowitz-Gordon I, Franck LS, Lyndon A. Information and power: women of color's experiences interacting with health care providers in pregnancy and birth. *Soc Sci Med.* 2019;238:112491. doi: 10.1016/j.socscimed.2019.112491.

45.   Hammond WP. Psychosocial correlates of medical mistrust among African American men. *Am J Community Psychol.* 2010;45(1-2):87-106. doi: 10.1007/s10464-009-9280-6.

46.   Fiscella K, Meldrum S, Franks P, et al. Patient trust: is it related to patient-centered behavior of primary care physicians? *Med Care.* 2004;42(11):1049-1055. doi: 10.1097/00005650-200411000-00003.

47.   Gordon HS, Street RL, Jr., Sharf BF, Kelly PA, Souchek J. Racial differences in trust and lung cancer patients' perceptions of physician communication. *J Clin Oncol.* 2006;24(6):904-909. doi: 10.1200/jco.2005.03.1955.

48.   Martin KD, Roter DL, Beach MC, Carson KA, Cooper LA. Physician communication behaviors and trust among black and white patients with hypertension. *Med Care.* 2013;51(2):151-157. doi: 10.1097/MLR.0b013e31827632a2.

49.   Johnson RL, Roter D, Powe NR, Cooper LA. Patient race/ethnicity and quality of patient-physician communication during medical visits. *Am J Public Health.* 2004;94(12):2084-2090. doi: 10.2105/ajph.94.12.2084.

50.   Powell W, Richmond J, Mohottige D, Yen I, Joslyn A, Corbie-Smith G. Medical Mistrust, Racism, and Delays in Preventive Health Screening Among African-American Men. *Behav Med.* 2019;45(2):102-117. doi: 10.1080/08964289.2019.1585327.

51.   Kaiser Family Foundation. The undefeated survey on race and health. 2020; https://www.kff.org/report-section/kff-the-undefeated-survey-on-race-and-health-main-findings/.

52.   Kennel J, Withers E, Parsons N, Woo H. Racial/Ethnic Disparities in Pain Treatment: Evidence From Oregon Emergency Medical Services Agencies. *Med Care.* 2019;57(12):924-929. doi: 10.1097/mlr.0000000000001208.

53.   Ndugga N, Artiga S. Disparities in health and health care: 5 key questions and answers. 2021; https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/. Accessed February 22, 2023.

54. Obermeyer Z, Powers B, Vogeli C, Mullainathan S. Dissecting racial bias in an algorithm used to manage the health of populations. *Science.* 2019;366(6464):447-453. doi: 10.1126/science.aax2342.

55. Valtis YK, Stevenson KE, Murphy EM, et al. Race and Ethnicity and the Utilization of Security Responses in a Hospital Setting. *J Gen Intern Med.* 2022. doi: 10.1007/s11606-022-07525-1.

56. Mojica CM, Bradley SM, Lind BK, Gu Y, Coronado GD, Davis MM. Initiation of Colorectal Cancer Screening Among Medicaid Enrollees. *Am J Prev Med.* 2020;58(2):224-231. doi: 10.1016/j.amepre.2019.09.015.

57. Levey N. She was already battling cancer. Then she had to fight the bill collectors. 2022; https://www.npr.org/sections/health-shots/2022/07/09/1110370391/cost-cancer-treatment-medical-debt#:~:text=The%20National%20Cancer%20Institute%20calculated,Usually%2C%20most%20costs%20are%20covered. Accessed December 6, 2022.

58. Dhar A, Bhatt J, Batra N, Rush B. US health care can't afford health inequities. 2022; https://www2.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html. Accessed December 6, 2022.

59. Iton A, Ross RK, Tamber PS. Building community power to dismantle policy-based structural inequity in population health. *Health Aff (Millwood).* 2022;41(12):1763-1771. doi: 10.1377/hlthaff.2022.00540.

60. Givens M, Kindig D, Inzeo P, Faust V. Power: the most fundamental cause of health inequity? 2018; https://www.healthaffairs.org/do/10.1377/forefront.20180129.731387/full/. Accessed February 7, 2023.

61. Apenteng BA, Kimsey L, Opoku ST, Owens C, Peden AH, Mase WA. Addressing the Social Needs of Medicaid Enrollees Through Managed Care: Lessons and Promising Practices from the Field. *Popul Health Manag.* 2022;25(1):119-125. doi: 10.1089/pop.2021.0142.

62. Findley S, Irigoyen M, Sanchez M, et al. Community empowerment to reduce childhood immunization disparities in New York City. *Ethn Dis.* 2004;14(3 Suppl 1):S134-141.

63. Popay J, Whitehead M, Carr-Hill R, et al. Public Health Research. *The impact on health inequalities of approaches to community engagement in the New Deal for Communities regeneration initiative: a mixed-methods evaluation.* Southampton (UK): NIHR Journals Library. Copyright © Queen's Printer and Controller of HMSO 2015. This work was produced by Popay et al. under the terms of a commissioning contract issued by the Secretary of State for Health. This issue may be freely reproduced for the purposes of private research and study and extracts (or indeed, the full

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64. Binka FN, Nazzar A, Phillips JF. The Navrongo Community Health and Family Planning Project. *Stud Fam Plann.* 1995;26(3):121-139.

65. Porter R, McIlvaine-Newsad H. Gardening in green space for environmental justice: food security, leisure and social capital. *Leisure/Loisir.* 2013;37(4):379-395. doi: 10.1080/14927713.2014.906172.

66. Farquhar S, Dobson N. Community and University Participation in Disaster-Relief Recovery. *Journal of Community Practice.* 2004;12(3-4):203-217. doi: 10.1300/J125v12n03_12.

67. The Rippel Foundation. A resident engagement strategy. 2018; https://rethinkhealth.org/wp-content/uploads/2018/12/RTH-ResEngageToolkit_12172018.pdf.

68. State Health and Value Strategies. Transformational community engagement to advance health equity. 2023; https://www.shvs.org/resource/transformational-community-engagement-to-advance-health-equity/.

69. White House. Executive order on advancing racial equity and support for underserved communities through the federal government. 2021; https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/. Accessed January 9, 2023.

70. Milken Institute School of Public Health. Equity vs. equality: what's the difference? 2020; https://onlinepublichealth.gwu.edu/resources/equity-vs-equality/. Accessed January 9, 2023.

71. White House. Recommendations from the equitable data working group. 2022; https://www.whitehouse.gov/wp-content/uploads/2022/04/eo13985-vision-for-equitable-data.pdf. Accessed January 9, 2023.