Using Data to Advance Health Equity

Carla Munns, Willamette Valley Community Health

Daesha Ramachandran, Health Share of Oregon

By then end of this session you will be able to…

1. Identify the difference between health disparities and health equity
2. Name key steps in examining data with an anti-bias lens
3. Learn how to use and share information to build momentum, leverage partnerships and support, and how to share strategic progress to reduce disparities
4. Understand how values shape equitable practice and begin to name where and how our values are in practice

Group Agreements

- Be present, this is an active process
- All of us are smarter than any one of us and each of us brings wisdom into this room that is important and valuable
- Move up, move up (move up your listening, move up your sharing)
- Act from curiosity
- Any others? …

Agenda

	Time
Introductions and Group Agreements • Name, Organization and Role • Ex. of how you leveraged a health equity strategy using data	15 min
Key Concepts • What is ‘health equity’ and what is ‘disparity’	10 min
Part 1: Case Studies and Storytelling • Understand our values • How do we embody principles of equity in practice	20 min
Part 2: Data Placemat Workshop • Explore how to make meaning of and identifying power in data	20 min
Part 3: Using Data to Drive Action • Thoughtful and community-focused	20 min
Closing and Reflections	5 min

Introductions

- Name, Organization and Role
- Please share a brief example of how you leveraged a health equity strategy using data

Key Concepts

- **Disparity:** any difference in health outcomes between groups within a population
- **Health equity:** the principle underlying a commitment to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants
- **Social determinants of health:** the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.
- **Population health:** the health outcomes of a group of individuals, including the distribution of such outcomes within the group, generally defined by healthcare organizations as either the communities in their geographic service area, or the patients actually seen in their organization.
- **Other key concepts to discuss?**

http://www.ihi.org/communities/blogs/making-sense-of-health-equity-terminology

Key Concepts

Health Disparity vs. Health Inequity

- Health disparity is different from health inequity

Health Disparity	Health Inequity
Differences in health outcomes between groups within a population, whether unjust or not	Differences in health outcomes that are systematic, avoidable, and unjust

http://www.ihi.org/communities/blogs/making-sense-of-health-equity-terminology

The means or the ends? What matters in health equity?

Part 1: Using Case Studies to Understand Values

Brainstorm:

Identify key, core values which underlay our work.

What values might be imbedded and applied when advancing health equity?

Part 1: Using Case Studies to Understand Values

Case Study Exercise

1) Identify key, core values that underlay our work
2) Examine where key values are at play, where they are absent and how they can be strengthened
3) How do you see values were added in looking at and applied data

Values to consider:

1) Person-centered
2) Strengths-based
3) Stakeholders/audience
4) Ownership of information
5) Power-sharing

Case Study 1: MAT Inequities

- **Reducing geographical health inequities for Medication Assisted Treatment (MAT)**
  - Marion and Polk Counties- one of highest regions for opioid use
  - Geographical evaluation of accessible MAT services in rural and urban areas
  - MAT services available only in urban areas = disparity
  - Looked at prescribing habits of clinicians
  - Data stratified by zip code

Case Study 1: MAT Inequities

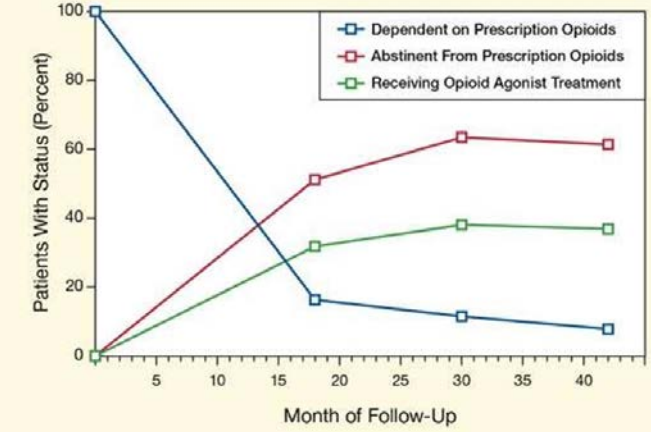
Zip Code	City / Town	County	2016 Rx Count	2016 Rank
97381	Silverton	Marion	2,120	1
97383	Stayton	Marion	1,418	2
97338	Dallas	Polk	1,336	3
97071	Woodburn	Marion	1,261	4

Case Study 1: MAT Inequities

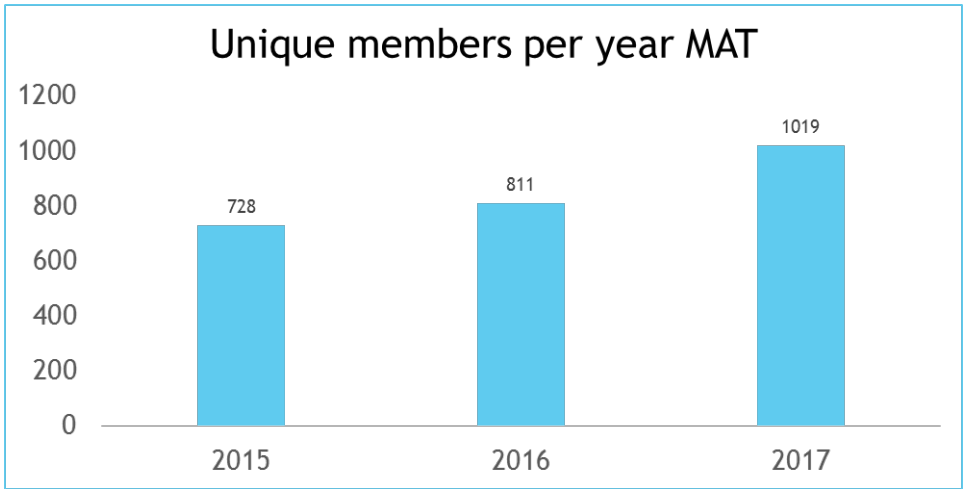
- **Reducing geographical health inequities for Medication Assisted Treatment (MAT)**
  - Identified large disparity existed geographically for MAT services
  - Health disparity for those living in rural regions
  - Educating and training providers about MAT services so rural members have access to treatment
  - Education to all providers on appropriate prescribing habits and best practice guidelines

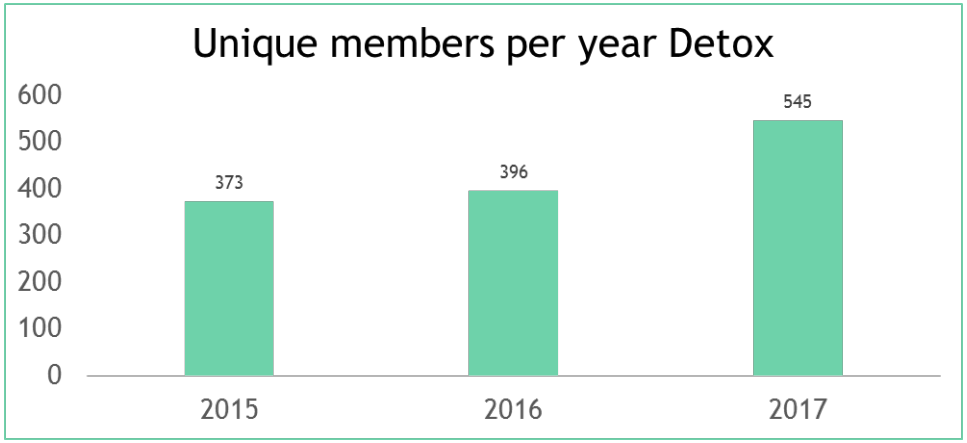
Case Study 1: MAT Inequities

- **Reducing geographical health inequities for Medication Assisted Treatment (MAT)**
  - Located two MAT trainings based on geographical regions of higher prescribing rates
  - Trained 27 clinicians in MAT, educated providers and community
  - Contracted with additional two MAT service providers to increase access
  - Training primary care providers to provide maintenance therapy at PCP office
  - Ongoing evaluation to ensure equitable standard of care



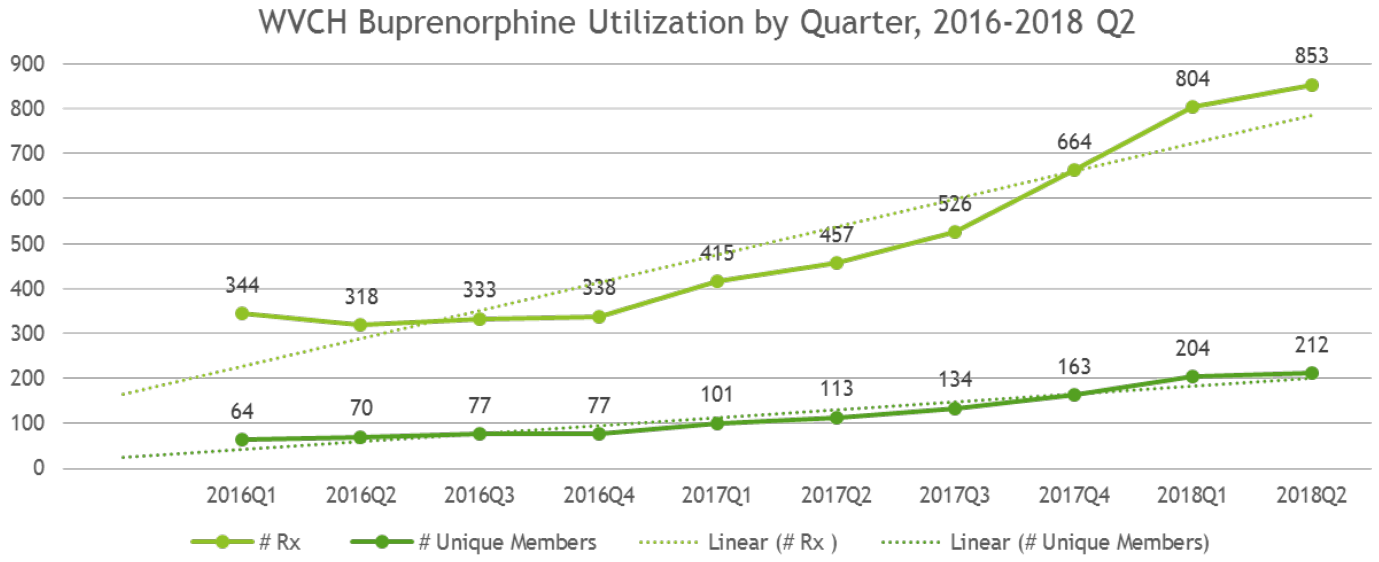
"Long-Term Follow-Up of MAT, 2015": National Institute on Drug Abuse





- More members continue to utilize MAT and detox services each year
- Projections for 2018 trend upwards of ~30%

Case Study 1: MAT Inequities



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3) Stakeholder audience
4) Ownership of power

Part 2: Data Placemat Workshop

- Explore how to make data and analyses meaningful
- Select 3-4 data points
- Work in small groups to tell a story with this data
  1. What story do you make from them?
  2. What else do you want to know?
  3. How would you go about finding answers to your questions?

Part 3: Using Data to Drive Equitable Transformation

"Never confuse movement with action."

-either Benjamin Franklin or Ernest Hemingway, depending on who you ask

Framing matters: acknowledging power and place

AP Associated Press AP - Tue Aug 30,11:31 AM ET

A young man walks through chest deep flood water after looting a grocery store in New Orleans on Tuesday, Aug. 30, 2005. Flood waters continue to rise in New Orleans after Hurricane Katrina did extensive damage when it

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Two residents wade through chest-deep water after finding bread and soda from a local grocery store after Hurricane Katrina came through the area in New Orleans, Louisiana.(AFP/Getty Images/Chris Graythen)

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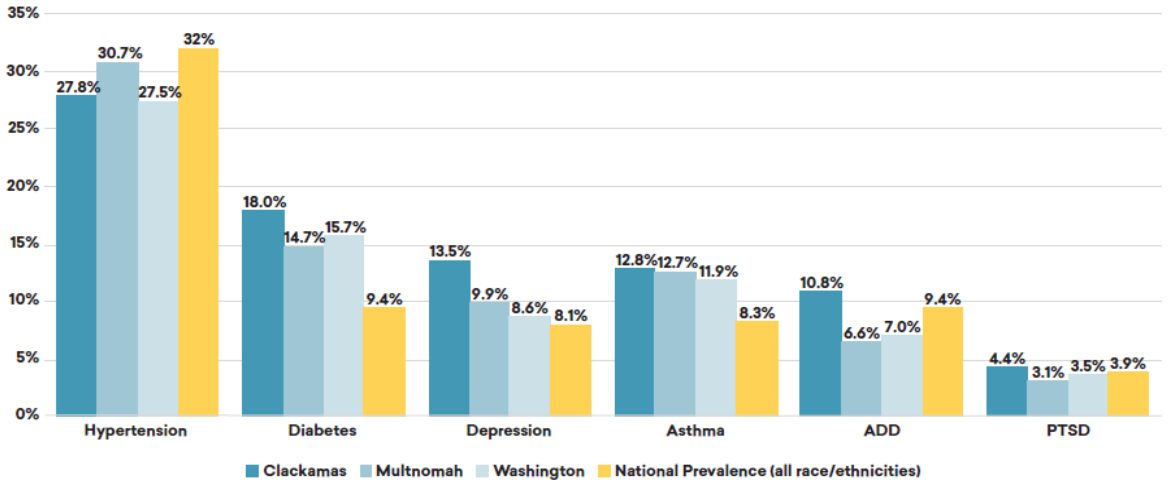
Part 3: Using Data to Drive Action
An ethno-racial approach

Equity moment

- To highlight the connections between racism, discrimination and health
- To arm organizations with data to respond
- To decenter whiteness as the norm

Top Health Conditions for Black/African Americans

For black/African-American members, hypertension was the top health condition among adults and asthma was the most prevalent condition among youth across all three counties.



health share

Represent our work as a partner in a person or community's success, not a the savior

Avoid case example syndrome

- *Malia (not her real name) came to our program because the trash in her apartment building was attracting mice and violating several housing codes. She recently moved here from Somalia. Her son had gone to the emergency room for pneumonia three times. Malia was referred to our program, and we forced her landlord to remove the trash from the building and hire an exterminator. Because of our program, Malia's son is feeling better and has a chance for a brighter future.*

Using Data to Advance Health Equity

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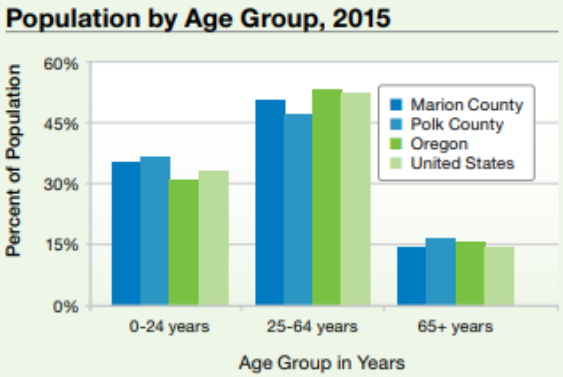
Case Study 2: Controlling STIs Using Equity Lens

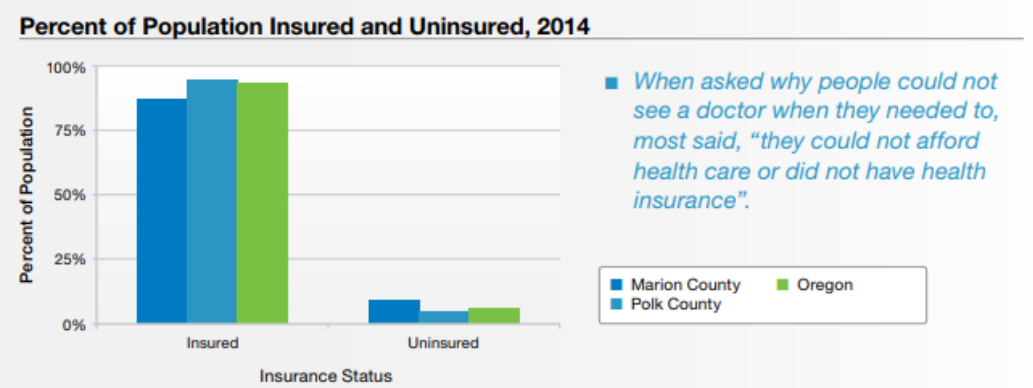
Marion & Polk Region

Marion County: 341,286 residents
Polk County: 83,696 residents
WVCH Enrollment: 103,000 members (2nd largest CCO by membership)

- 50% under the age of 18 years old
- 60% under the age of 25 years old



Marion and Polk County Health Status Report 2017



Case Study 2: Controlling STIs Using Equity Lens

Marion & Polk STI Rates

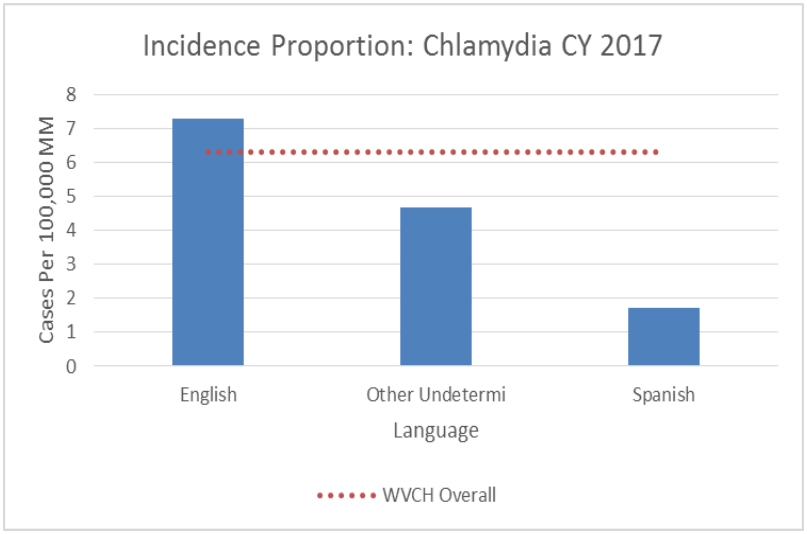
Chlamydia, Gonorrhea & HPV Immunization rates

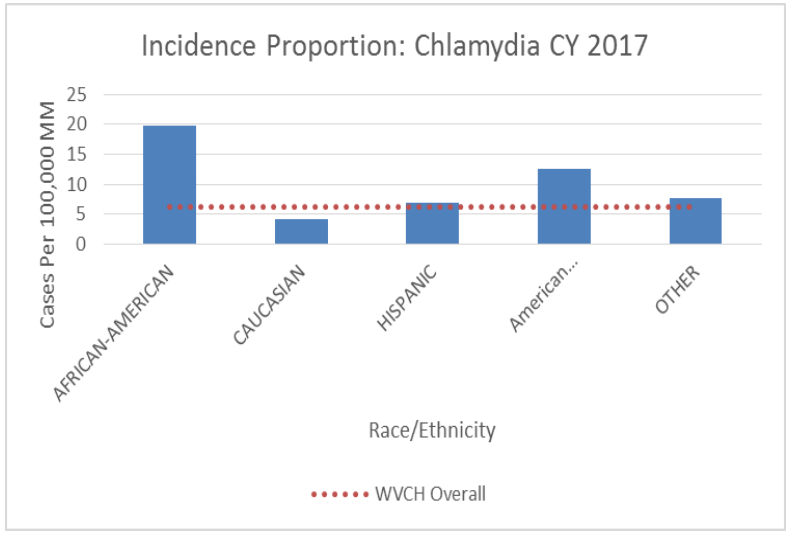
Red = Rate is worse (higher/lower) than the state
Green = Rate is better (higher/lower) than the state
↑ = Over time trend is increasing in undesired direction
↑ = Over time trend is increasing in the desired direction
†† = Rate is significantly different from the state (alpha = 0.05)
*Rate = Incidence Rate = Number of new cases in time period per 100,000 people at risk
NR = Not reported

Disease/Infection (Time period/ Year)	Number of Cases in Region	Marion County Rate* (/ 100K)	Polk County Rate* (/100K)	Trend	Disparities Detected
Chlamydia (2011-2015)[1]	8422	444†	322†	↑	Black/African Americans, Pacific Islanders, American Indian/Alaskan Natives, Hispanics, Females, 18 – 25 year olds
Gonorrhea (2011-2015)[1]	728	39†	24†	↑	Black/African Americans, Males, 20 - 29 year olds
Cervical Cancer (2010-2014)[5]	64	10†	NR	NR	No
Vaccinations	**Number of Cases in Region**	**Marion County Rate (%)**	**Polk County Rate (%)**	**Trend**	**Disparities Detected**
HPV Adolescents (13-17) (2016)[4]	NR	32%	28%	↑	Males

Case Study 2: Controlling STIs Using Equity Lens

Medicaid STI Prevalence Rates- 2017



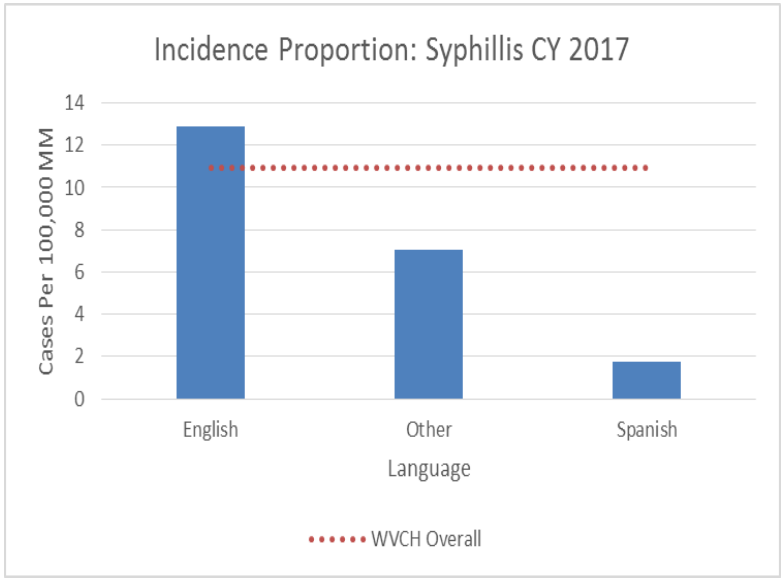


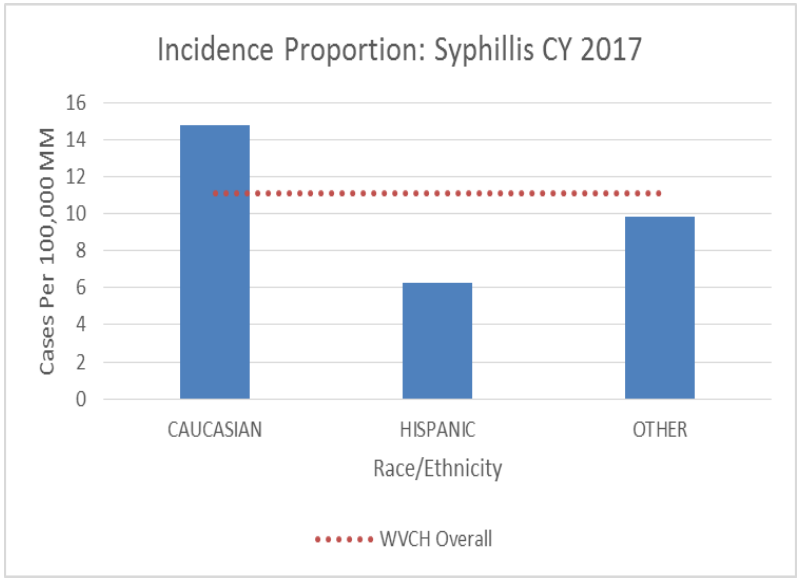
WILLAMETTE VALLEY community health

WVCH claims data, September 2018

Case Study 2: Controlling STIs Using Equity Lens

Medicaid STI Prevalence Rates- 2017





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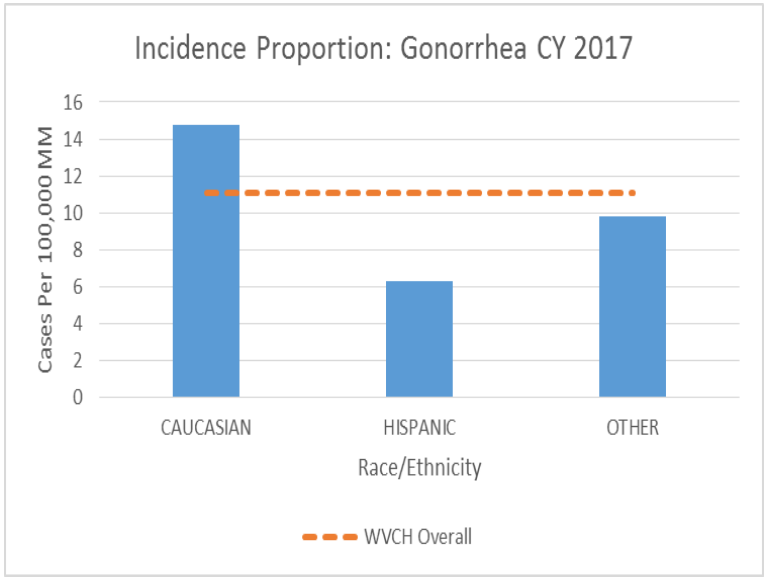

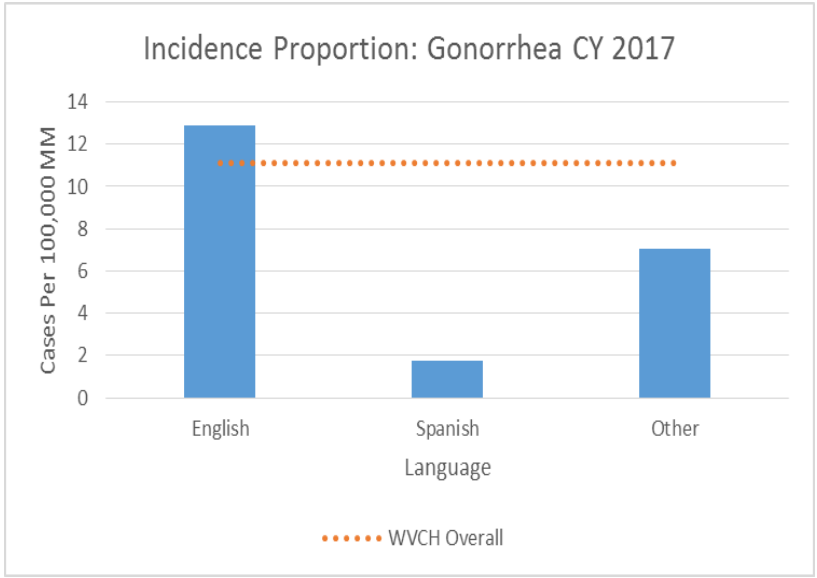

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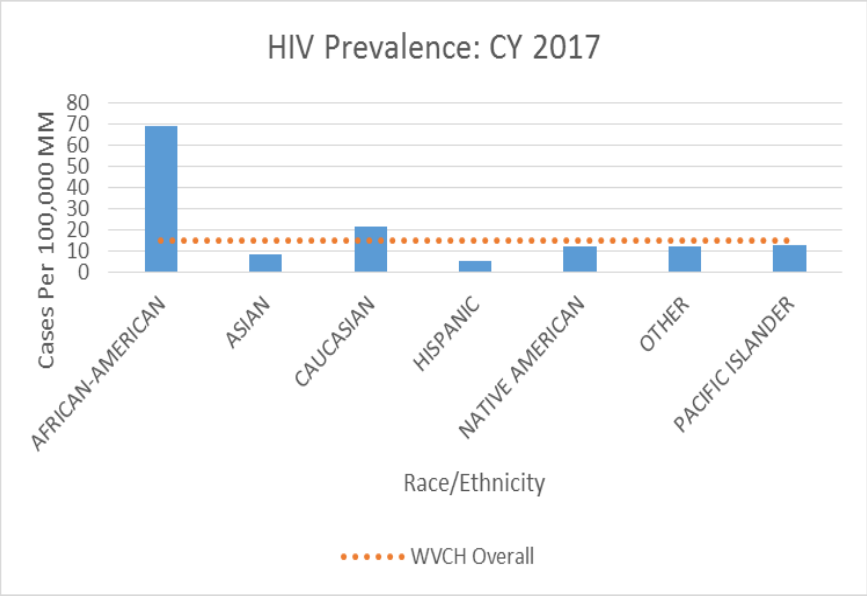

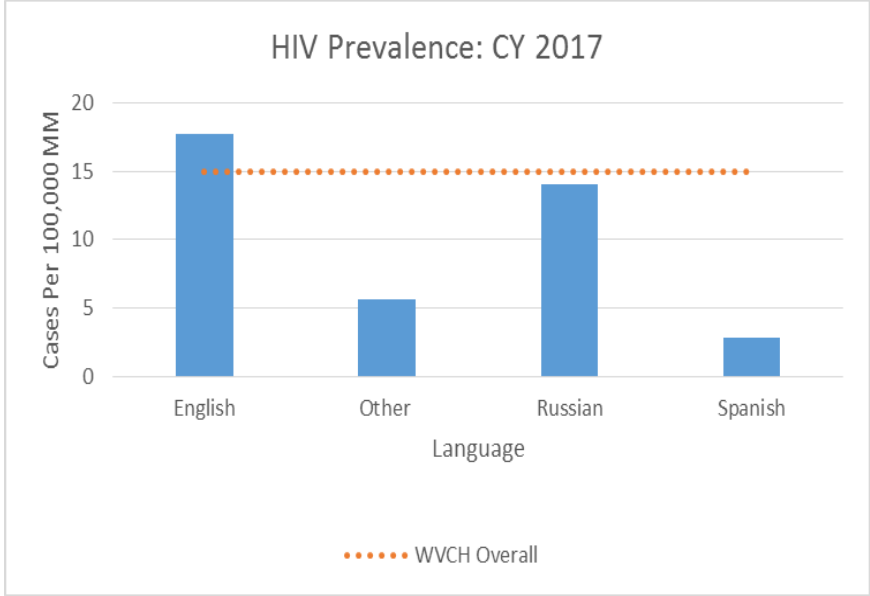

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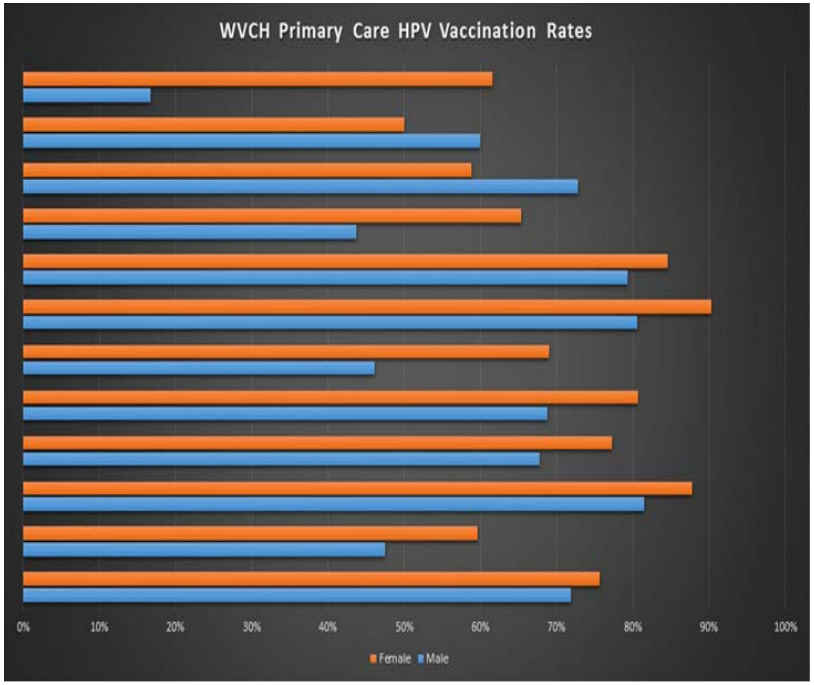
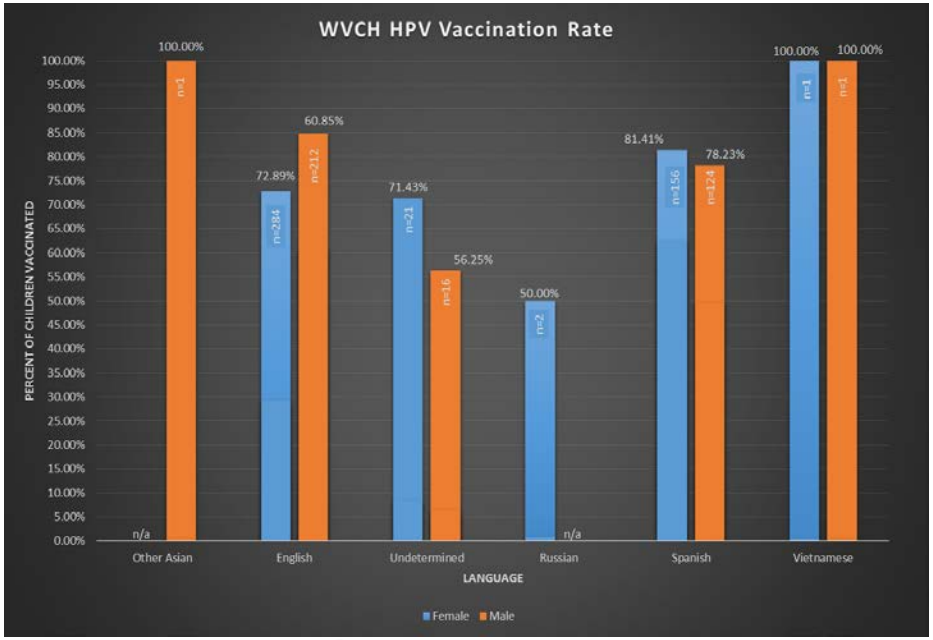
Case Study 2: Controlling STIs Using Equity Lens

Medicaid HPV Vaccination Rates- 2017





WILLAMETTE VALLEY community health

WVCH claims data, September 2018

Case Study 2: Controlling STIs Using Equity Lens

Cross-Jurisdictional Approach to Controlling Sexually Transmitted Infections in the Willamette Valley

Health disparities detected:

- Chlamydia
  - Pacific Islander, African-American, American Indian/Alaska Natives (AI/AN), Hispanics, Females, 18-25 year olds
  - WVCH: African-American, AI/AN and Caucasian
- Gonorrhea
  - African-American, Males, 20-19 yo
  - WVCH: English-speaking and Caucasian
- Syphilis
  - WVCH: English-speaking and Caucasian
- HIV
  - WVCH: Russian-speaking and African-American
- HPV Vaccinations
  - Male adolescents
  - PCP clinic-specific disparities

Case Study 2: Controlling STIs Using Equity Lens

High Level Goals

- Establish an active communicable disease (CD) coalition to garner community support and create ownership for health equity, communicable disease control and prevention
- Develop and implement a Regional Health Equity Plan for sustainable CD initiatives and programs
- Educate and train clinical providers on best practices for testing and treatment of STIs
- Increase control of STIs through increases in treatment capacity, reduction of prevalence rates, establish systems to control outbreaks and prevent future outbreaks

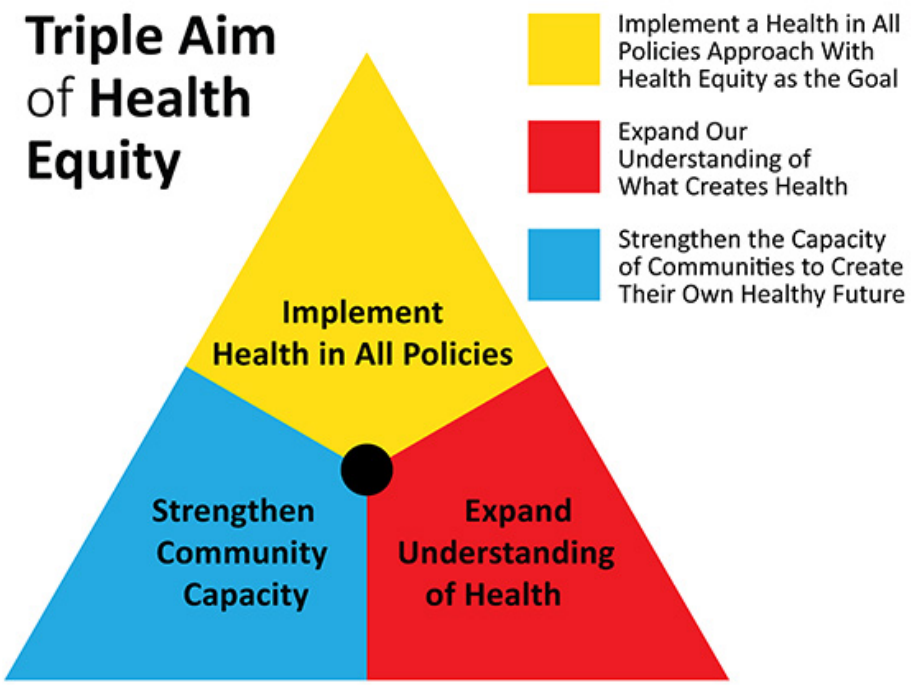


Image: Association of State and Territorial Health Officials, 2016

Part 3: Using Data to Drive Action

Examples in motion:

- Regional CHA and CHIP
  - Share data, align metrics and focus areas, share in oversight and leadership
  - Shared data → partnered action
- Expanding immunization capacity in rural areas
- Reproductive health services access and utilization of PCPCH
- Public Health Modernization (Case Study 2)

Part 3: Using Data to Drive Action

Case Study 2: Controlling STIs Using Equity Lens

Objectives	Outcomes: This Biennium	Outcomes: Beyond
Cross-Jurisdictional Sharing Model	• Policies adopted and relationships established • Marion will train Polk Co. in CD Model	Relationships, systems and sharing model is sustained and ongoing
Community buy-in for communicable disease (CD)	Develop an active CD coalition with cross-agency buy-in, Focus Groups, diverse participation, key informant interviews, identify and engage stakeholders	CD advocacy and buy-in sustains coalition beyond biennium funding
Regional Health Equity Plan	Develop a health equity action plan to establish and implement policies and systems to reduce CD control-related disparities	CD equity policies will reduce (and continue to reduce) CD control-related disparities
Educated and trained clinical network on best practices for testing and treatment of STIs	• Provide 6 provider trainings to increase knowledge of best practices • Increase adequate gonorrhea Tx in Polk Co • Maintain/improve gonorrhea Tx in Marion Co	Improved system coordination and communication
STI Control: Increase in Tx capacity, reduce incidence rates, reduce outbreaks and establish systems to control future outbreaks	• Increase gonorrhea case and contact-finding capacity in Polk Co • Improve HPV vaccine rates regionally	Lower rates of STIs in Marion & Polk Counties