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TRUST**

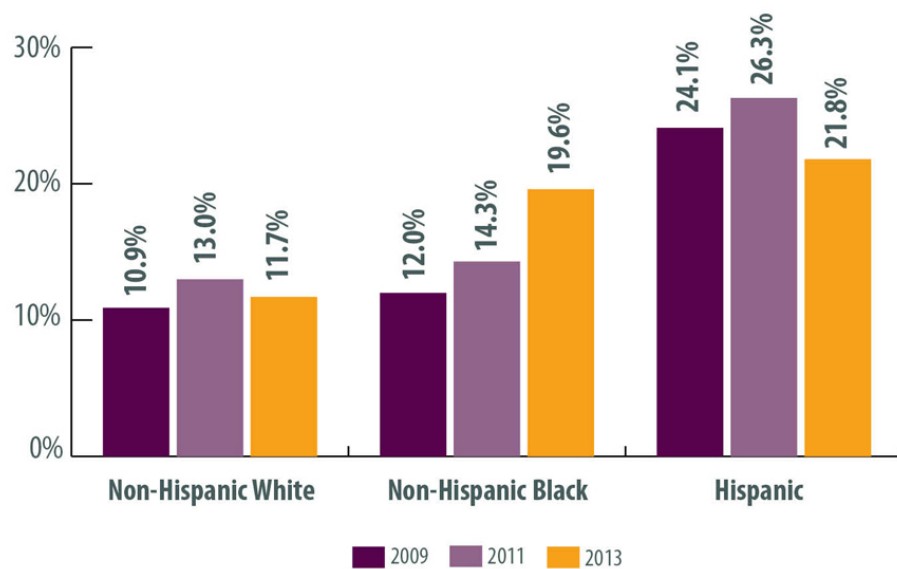
HEALTH EQUITY LEARNING SERIES

Solutions for Health Equity

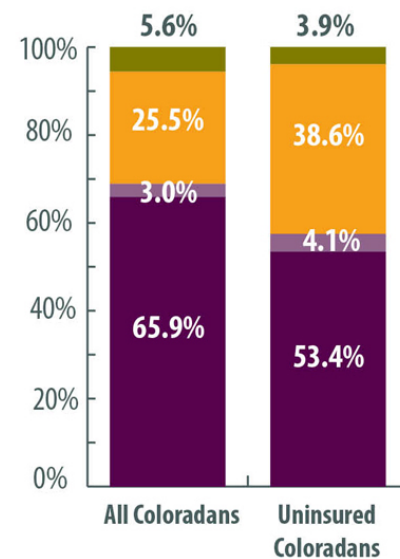


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**Uninsured Rates by Race/Ethnicity,
Colorado, 2009-2013**



**Race/Ethnicity Distribution,
Uninsured Coloradans versus
All Coloradans, 2013**



■ Non-Hispanic White ■ Non-Hispanic Black
■ Hispanic ■ Other



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Discussion Paper

The Patient-Centered Medical Home: A Path Toward Health Equity?

Winston Wong, Kaiser Permanente; Karen M. Anderson, Institute of Medicine; Irene Dankwa-Mullan, National Institutes of Health; Melissa A. Simon, Northwestern University; and William A. Vega, University of Southern California*

September 2012

*Participants in the activities of the IOM Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

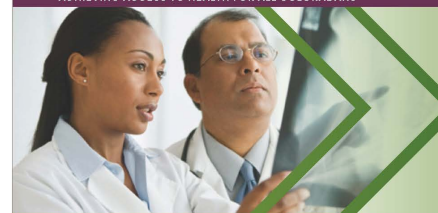
The views expressed in this discussion paper are those of the authors and not necessarily of the authors' organizations or of the Institute of Medicine. The paper is intended to help inform and stimulate discussion. It has not been subjected to the review procedures of the Institute of Medicine and is not a report of the Institute of Medicine or of the National Research Council.

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES
Advising the nation • Improving health



ACHIEVING ACCESS TO HEALTH FOR ALL COLORADANS

OCTOBER 2013



HIGHLIGHTS of the report on *Health Equity and Racial and Ethnic Workforce Diversity*

How to Address the Shortage of Racially and Ethnically Diverse Health Professionals

Prepared for The Colorado Trust by Suzuko Shimasaki; Sherry Freedland Walker, editor

» ALTHOUGH THEIR NUMBERS ARE GROWING IN COLORADO AND THE NATION, RACIAL AND ETHNIC MINORITIES ARE STRICTLY THE MINORITY IN THE HEALTH CARE WORKFORCE. For instance:

- Racial and ethnic minorities are underrepresented across all health professions in Colorado with the exception of certified nurse aides.
- Almost all (98%) of Colorado's local health department top executives are white.
- Nationally, people of color make up 14 percent of physicians, 5 percent of dentists, 14 percent of nurses, and 17 percent of city and county public health officials.
- Almost all (98%) senior managers in health care organizations across the nation are white.

This situation does not match the evolving racial and ethnic makeup of the nation or Colorado. People of color make up more than 30 percent of Coloradans and 35 percent of the U.S. population. Given that communities of color experience a disproportionate burden of morbidity and mortality, increasing workforce diversity is vital to eliminating health disparities. Studies show providers of color are more likely to practice in underserved areas with greater racial and ethnic minority populations and serve patients of color who are uninsured or underinsured.

The Colorado Trust paper, *Health Equity and Racial and Ethnic Workforce Diversity*, examines the makeup of the health care workforce in Colorado and nationally, health equity provisions in the 2010 Patient Protection and Affordable Care Act (ACA) that pertain to workforce diversity and misconceptions that stand

as barriers to diversifying the health care workforce. It also highlights how some Colorado organizations are increasing their workforce diversity and provides recommendations for health care organizations. These recommendations come from recipients of grants and the technical assistance providers under the Equality in Health initiative, a seven-year effort funded by The Colorado Trust to reduce racial and ethnic health disparities in Colorado.

"There is a comfort level that is almost immediately apparent when [patients] are served by someone like them. It makes a phenomenal difference."

— *Kraig Burleson, Chief Executive Officer, Inner City Health Center, Denver*

The Colorado Trust <



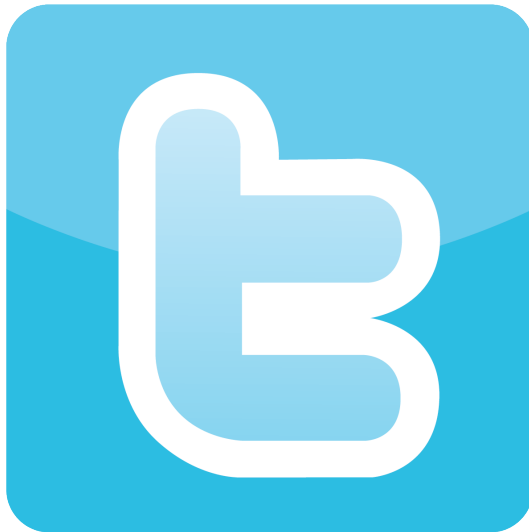
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Viewing Parties

- Alamosa
- Colorado Springs
- Durango
- Eagle
- Fort Collins
- Frisco
- Grand Junction
- Gunnison
- Lamar
- Leadville
- Montrose
- Monte Vista
- Pueblo
- Rifle
- Steamboat
- Telluride
- Yuma



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#healthequityTCT



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Today's Presenters

Anthony Iton, MD

Senior Vice President
The California Endowment

Winston Wong, MD

Medical Director
Kaiser Permanente

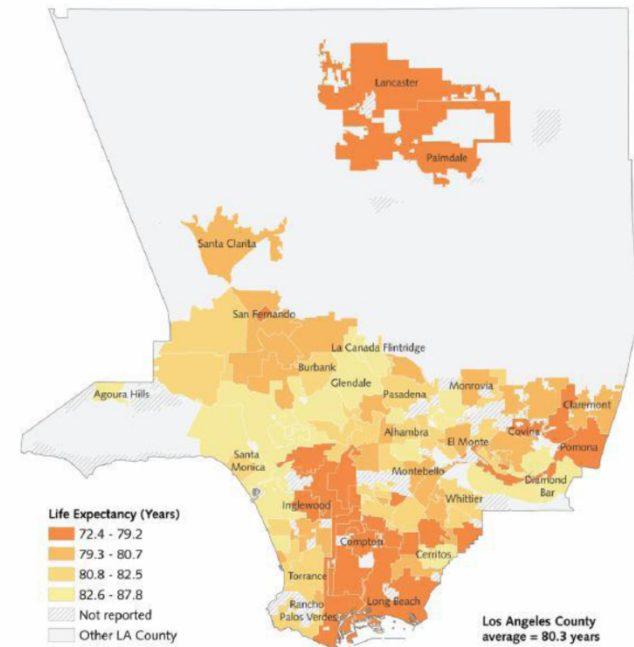
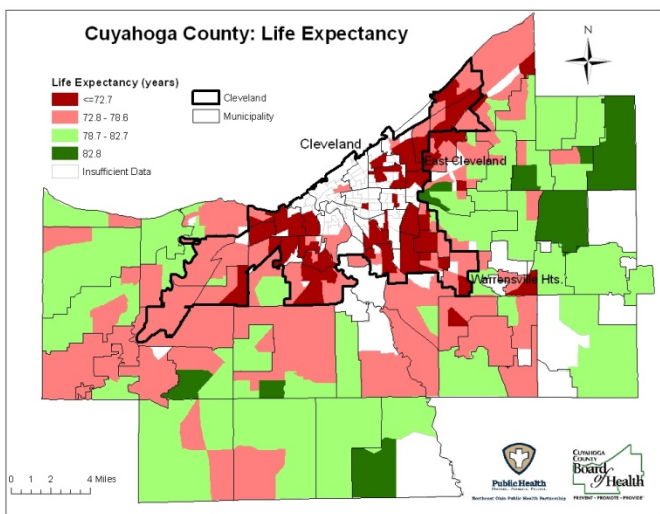
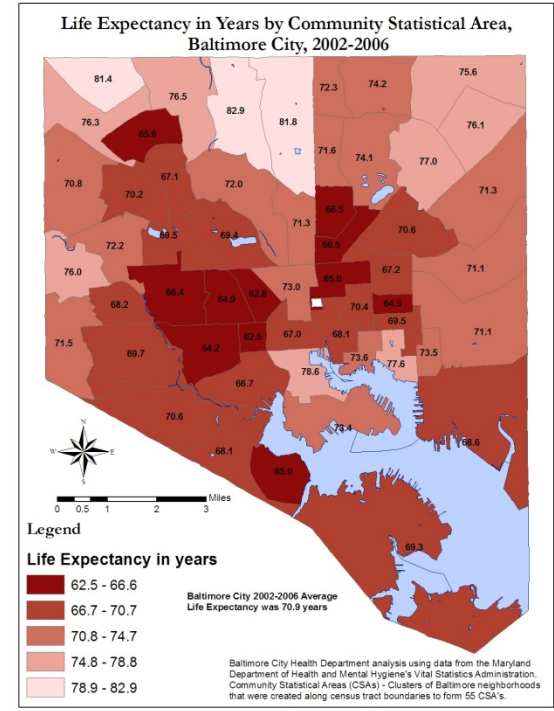
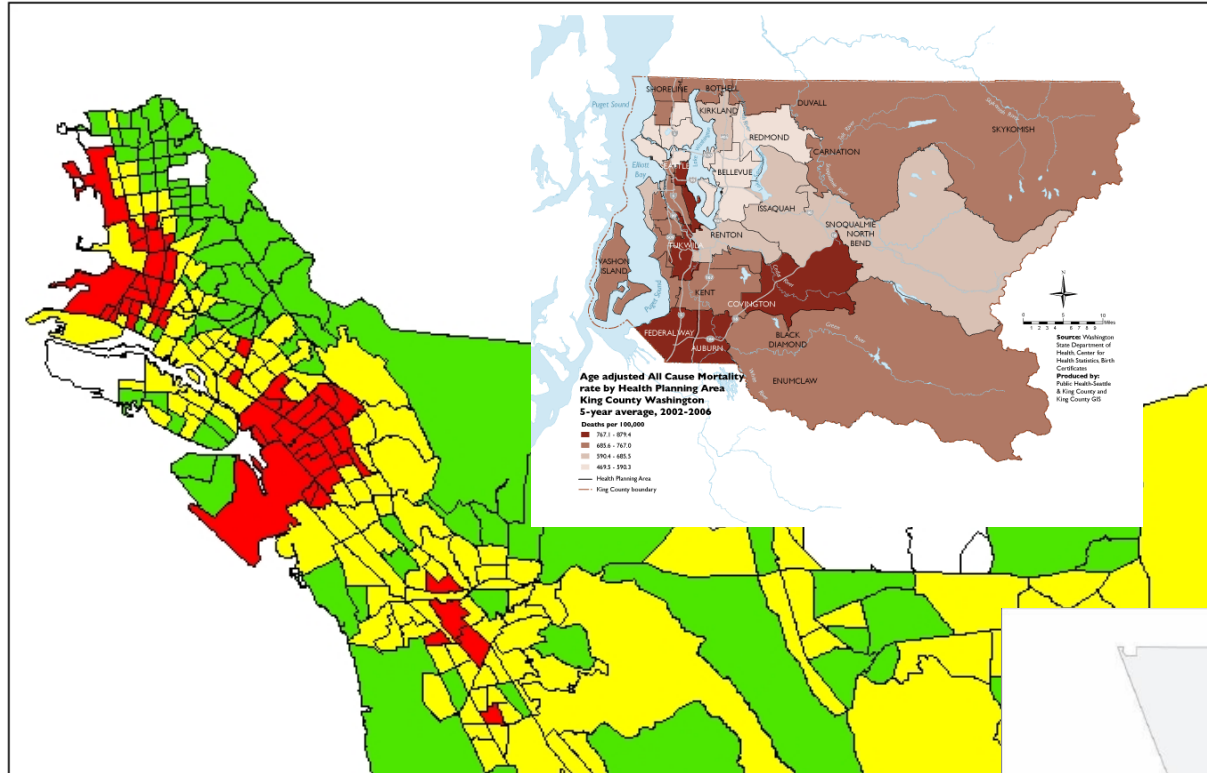
Health is political

*“The struggle over the allocation
of scarce and precious social
goods”*

Argument

1. Where you live influences how long you live
2. Policy/politics shapes neighborhood design & resources- (inner cities, Chinatowns, barrios)
3. Living in a resource deprived community is chronically stressful
4. Chronic stress produces chronic disease
5. Medical care is a necessary but insufficient tool

Life Expectancy by Tract





ZIP CODE
8769
EXPECTANCY

73

low.org

ZIP CODE
94301
LIFE EXPECTANCY

86

Your ZIP Code
shouldn't predict
how long you'll live.

health
happens
here

ZIP CODE
90002
LIFE EXPECTANCY

73

Policy/Politics Shapes Neighborhoods

and resources.....



II

1
2 That plaintiffs are the owners of lots or parcels of
3 land within and being a portion of Tract 597, Washington
4 Township, Alameda County, California, as said tract is de-
5 lineated and so designated on map thereof recorded in the office
6 of the County Recorder, Alameda County, California, in Book
7 17 of Maps, page 95. That plaintiffs are the owners of record
8 and in fact respectively of the following lots in said tract:
9 Mouzon Matthews and Florence Matthews, his wife, lot 28;
10 Louie W. Nielsen and Isabel E. Nielsen, his wife, lot 29;
11 E. A. Miller and Marybelle Miller, his wife, lot 18.

III

12
13 That under date of April 7, 1941, Frank E. Clarke, Mabel
14 S. Clarke, Ada E. Rowe, E. W. Stenhammer, and Esther Stenhammer,
15 did execute and thereafter cause to be recorded on the 30th day
16 of April, 1941, in Book 4058 of Official Records, at page 211,
17 in the office of the County Recorder of Alameda County, California,

"(5) no person or persons of the Mexican race,
or other than the CAUCASIAN race shall use or
occupy any building or any lot, except that this
covenant shall not prevent occupancy by domesti
servants of a different race domiciled with an
owner, tenant or occupant thereof.

27 at which time said covenants and restrictions shall
terminate.

28 "(10) If the parties hereto, or any of them, or their
29 heirs, successors or devisees, executors or adminis-
30 trators or assigns, shall violate, or attempt to vio-
31 late, any of the covenants or restrictions herein con-
32 tained before January 1, 1961, any owner or owners of
the remainder of the premises herein described, or of

The FHA and Covenants

- Federal Housing Administration recommended racially restrictive covenants to receive mortgage guarantees.

“It is necessary that properties shall continue to be occupied by the same social and racial groups” - Federal Housing Administration Underwriting Manual 1938.

- 30 year mortgages, 10% down payment.
- Without FHA, 33%-50% down payment. Far shorter mortgages (higher monthly payments).

Exclusionary Policies & Legacy

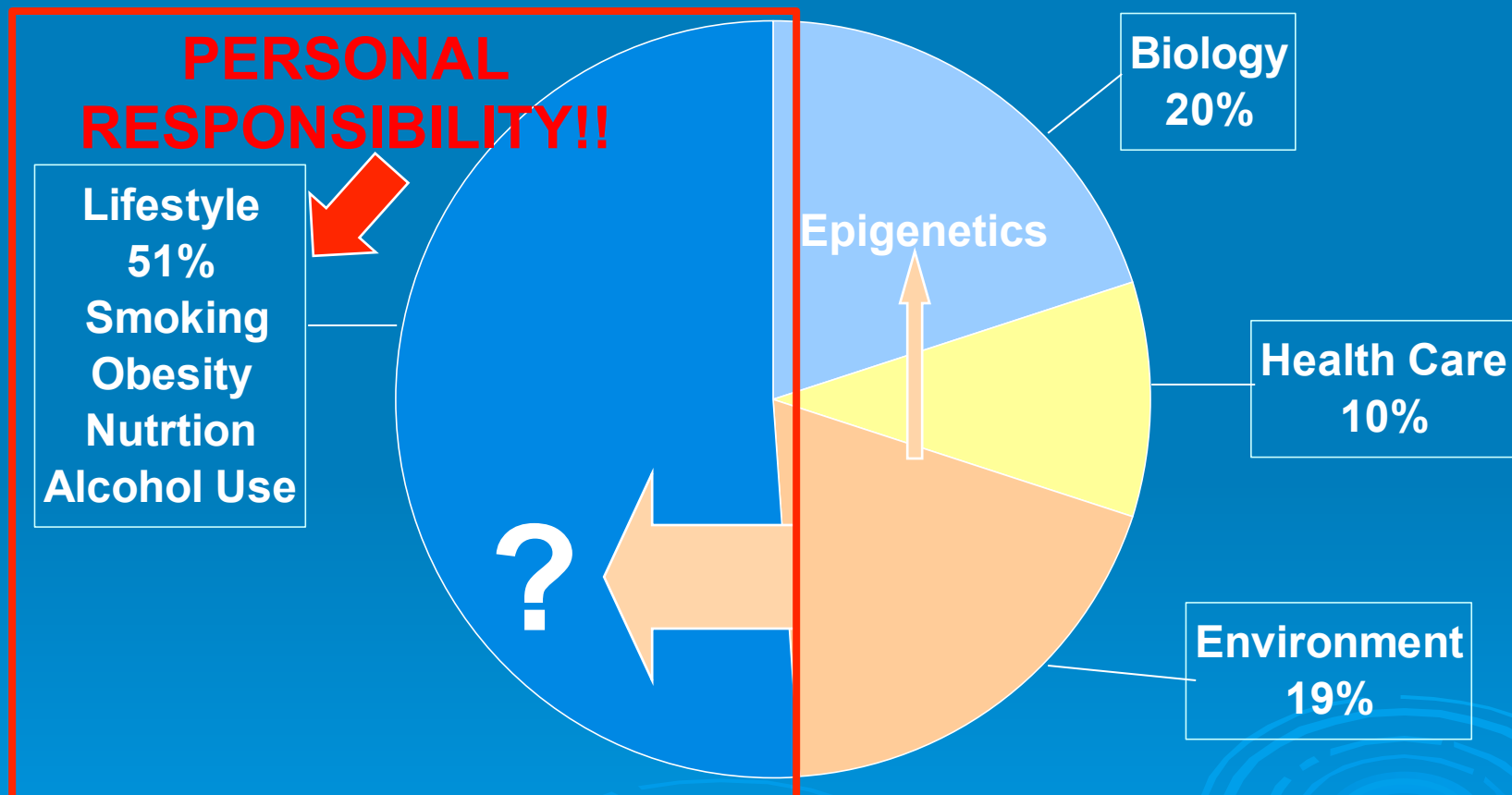
- Redlining, racially restrictive covenants
- School segregation, funding
- Health insurance
- Transportation priorities
- Predatory lending
- Affordable housing, sub prime lending
- Immigration
- Marriage
- Legacy-Social Security, GI Bill.....

**How Does Your
“*Neighborhood*” Get
Under Your Skin?**



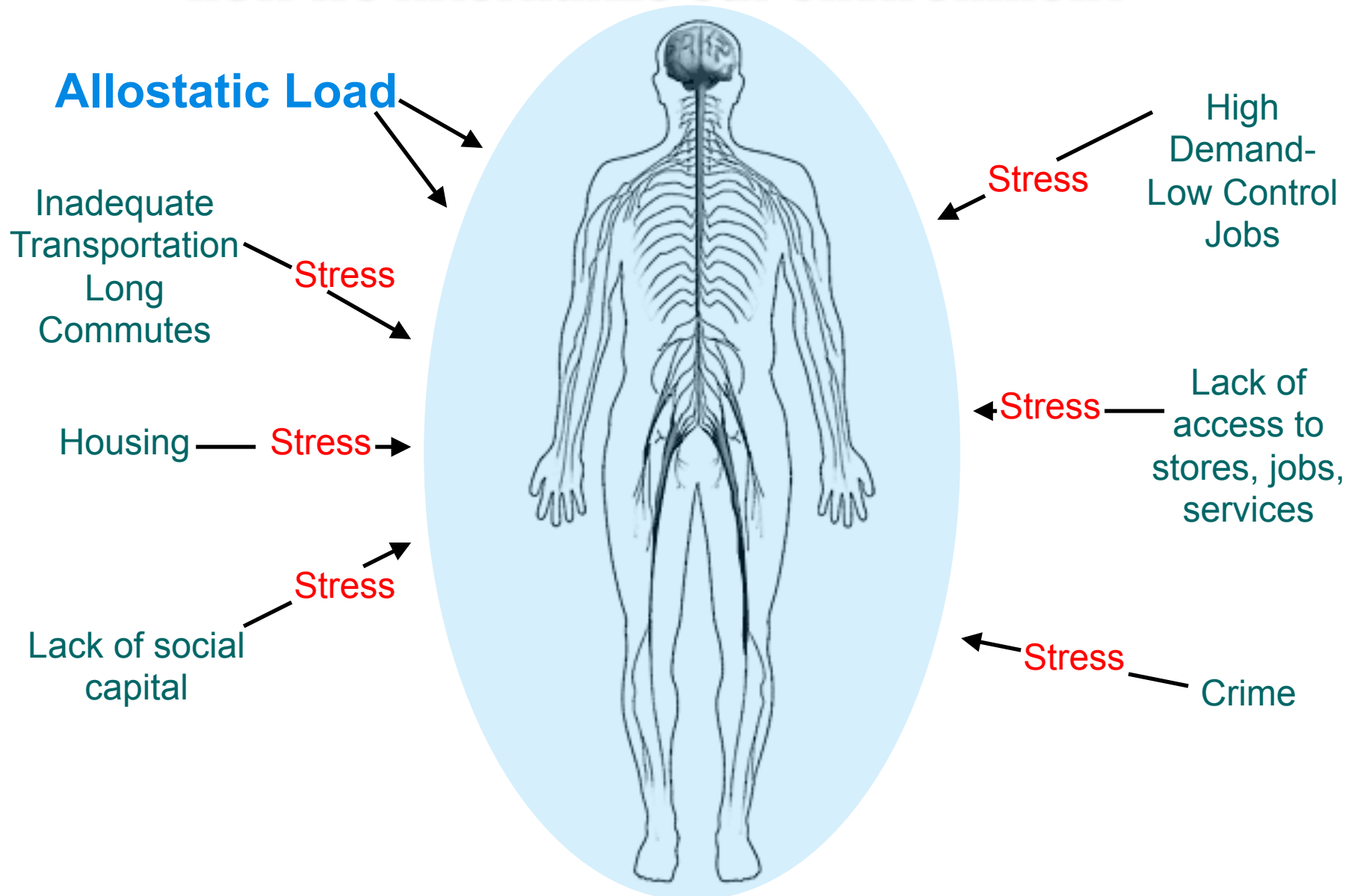
Actual Causes of Death

A bridge between genotype and phenotype— a phenomenon that changes the final outcome of a locus or chromosome without changing the underlying DNA sequence



Source: McGinnis, J.M and Foege, W.H. (1993). "Actual Causes of Death in the United States," Journal of the American Medical Association.

When the external becomes internal: How we internalize our environment



Stressed vs. Stressed Out

➤ Stressed

- Increased cardiac output
- Increased available glucose
- Enhanced immune functions
- Growth of neurons in hippocampus & prefrontal cortex

➤ Stressed Out

- Hypertension & cardiovascular diseases
- Glucose intolerance & insulin resistance
- Infection & inflammation
- Atrophy & death of neurons in hippocampus & prefrontal cortex

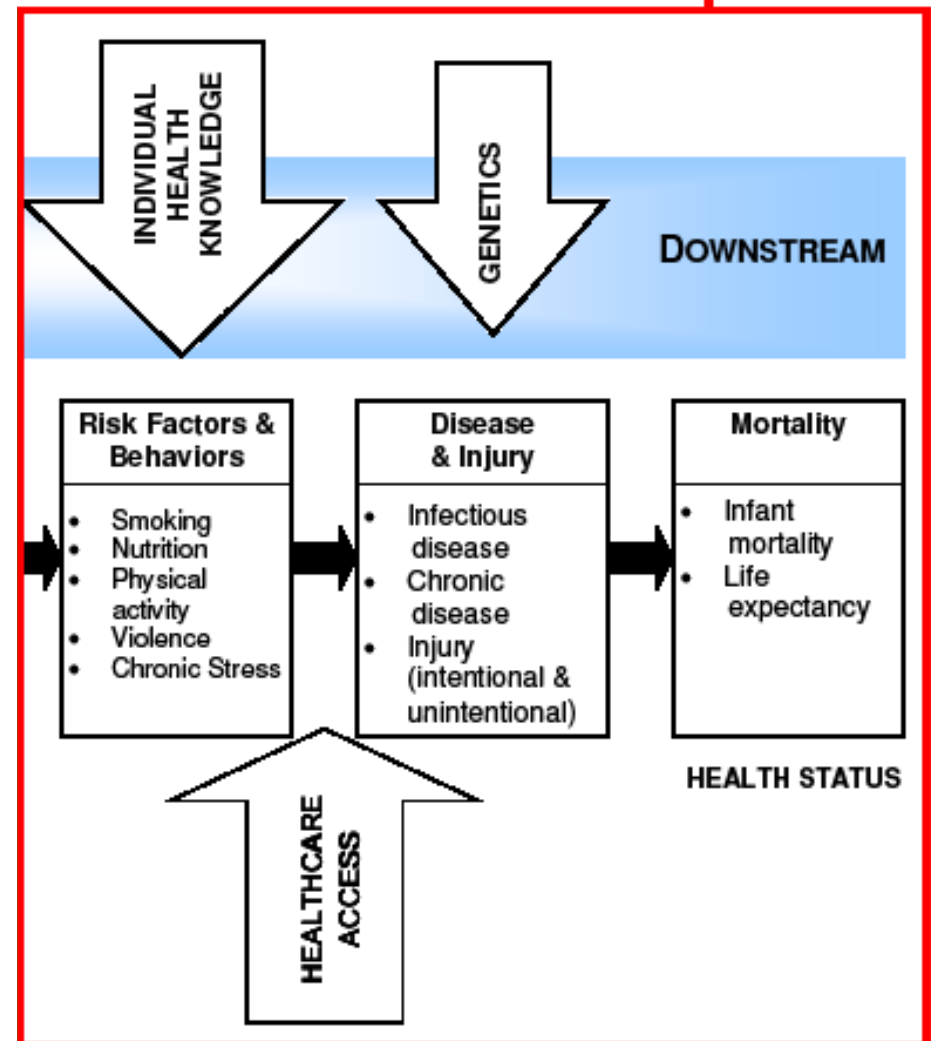
Equal Postsecondary Attendance Rates for Low-Income, High Achievers and High-Income Low Achievers

Achievement Level (in quartiles)	Low-Income	High-Income
First (Low)	36%	77%
Second	50%	85%
Third	63%	90%
Fourth (High)	78%	97%

Source: NELS: 88, Second (1992) and Third Follow up (1994); in, USDOE, NCES, NCES Condition of Education 1997 p. 64

A Framework for Health Equity

Medical Model

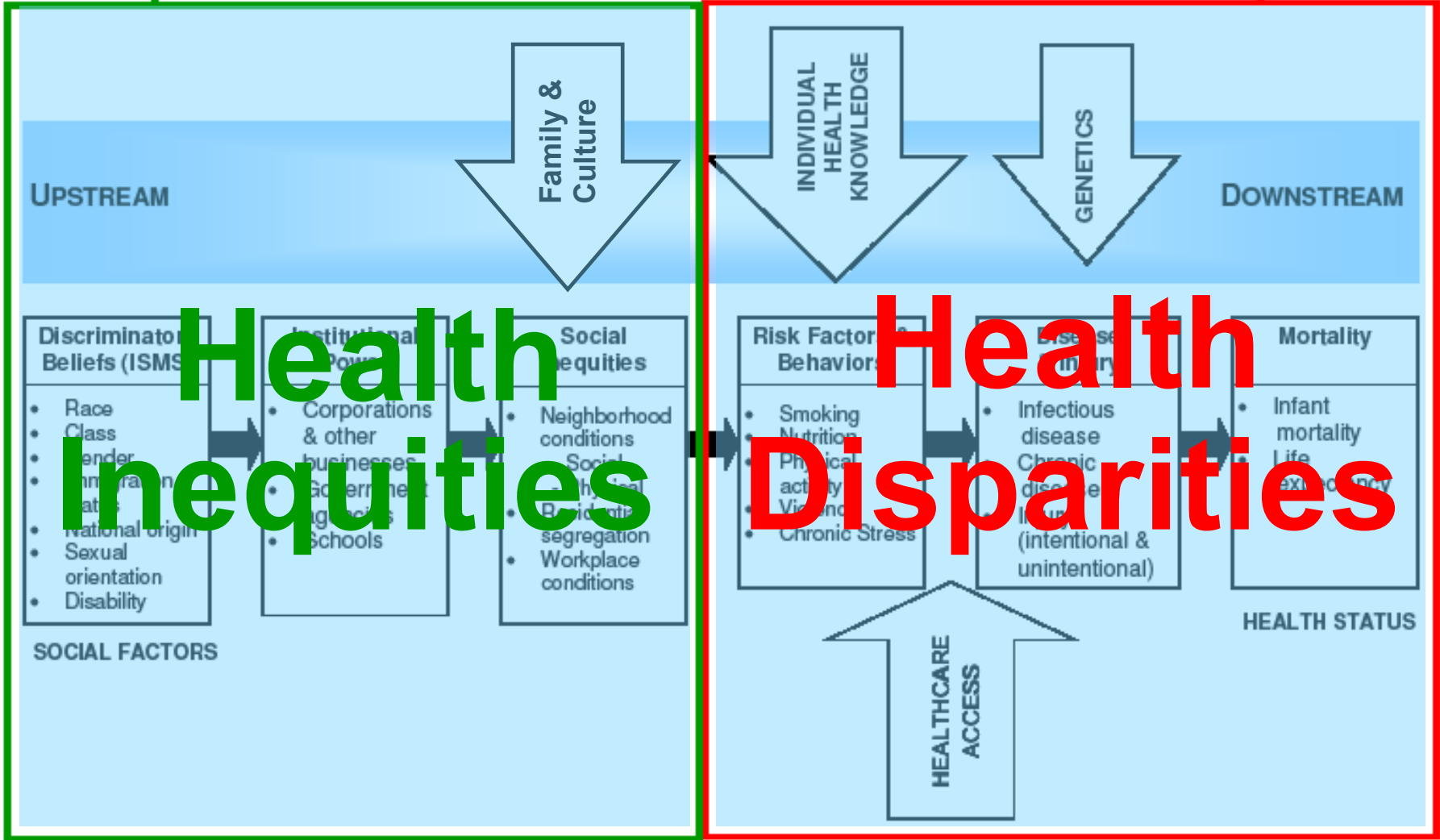


- Adapted by ACPHD from the Bay Area Regional Health Inequities Initiative, Summer 2008

A Framework for Health Equity

Socio-Ecological

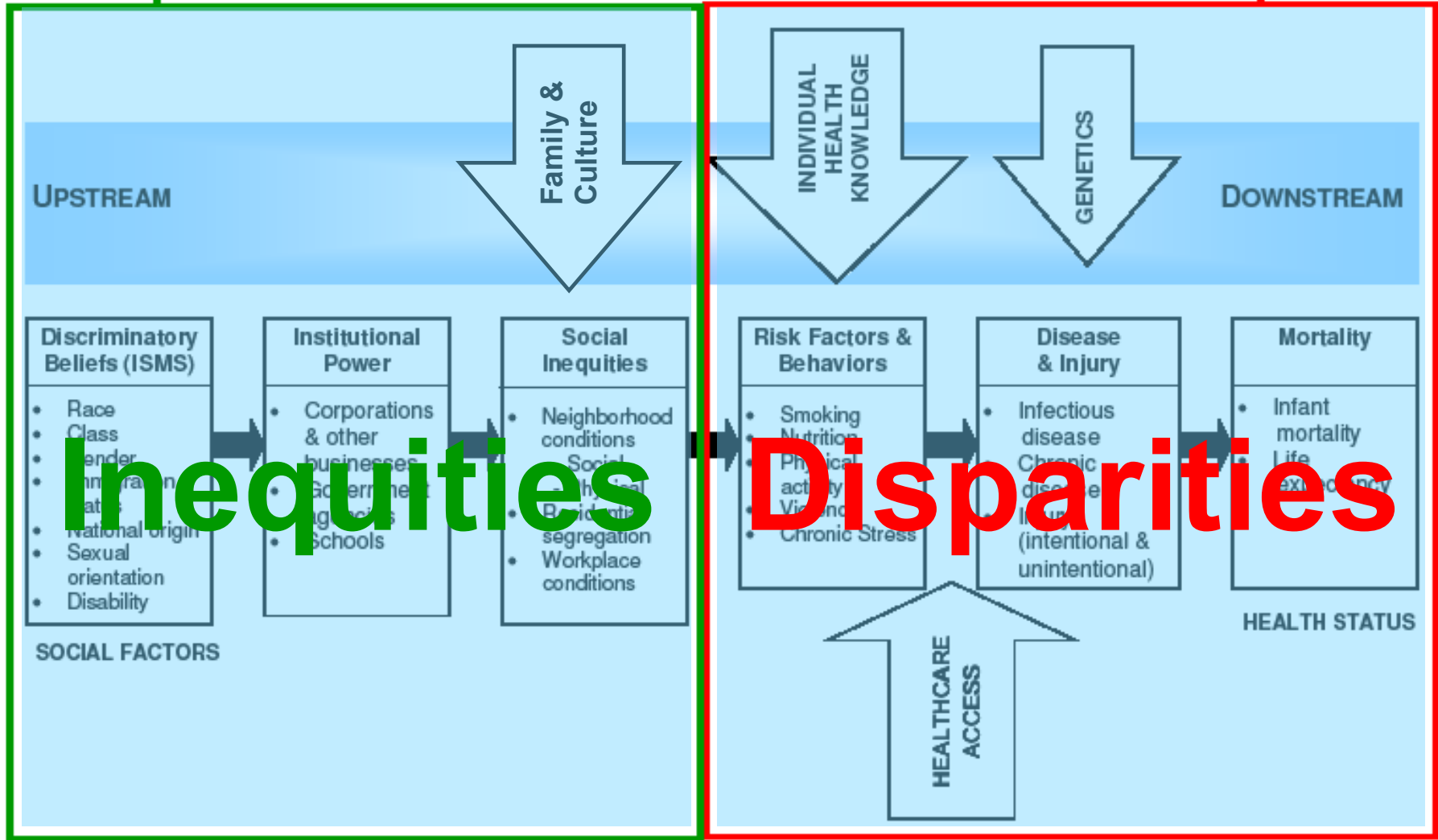
Medical Model



A Framework for Health Equity

Socio-Ecological

Medical Model

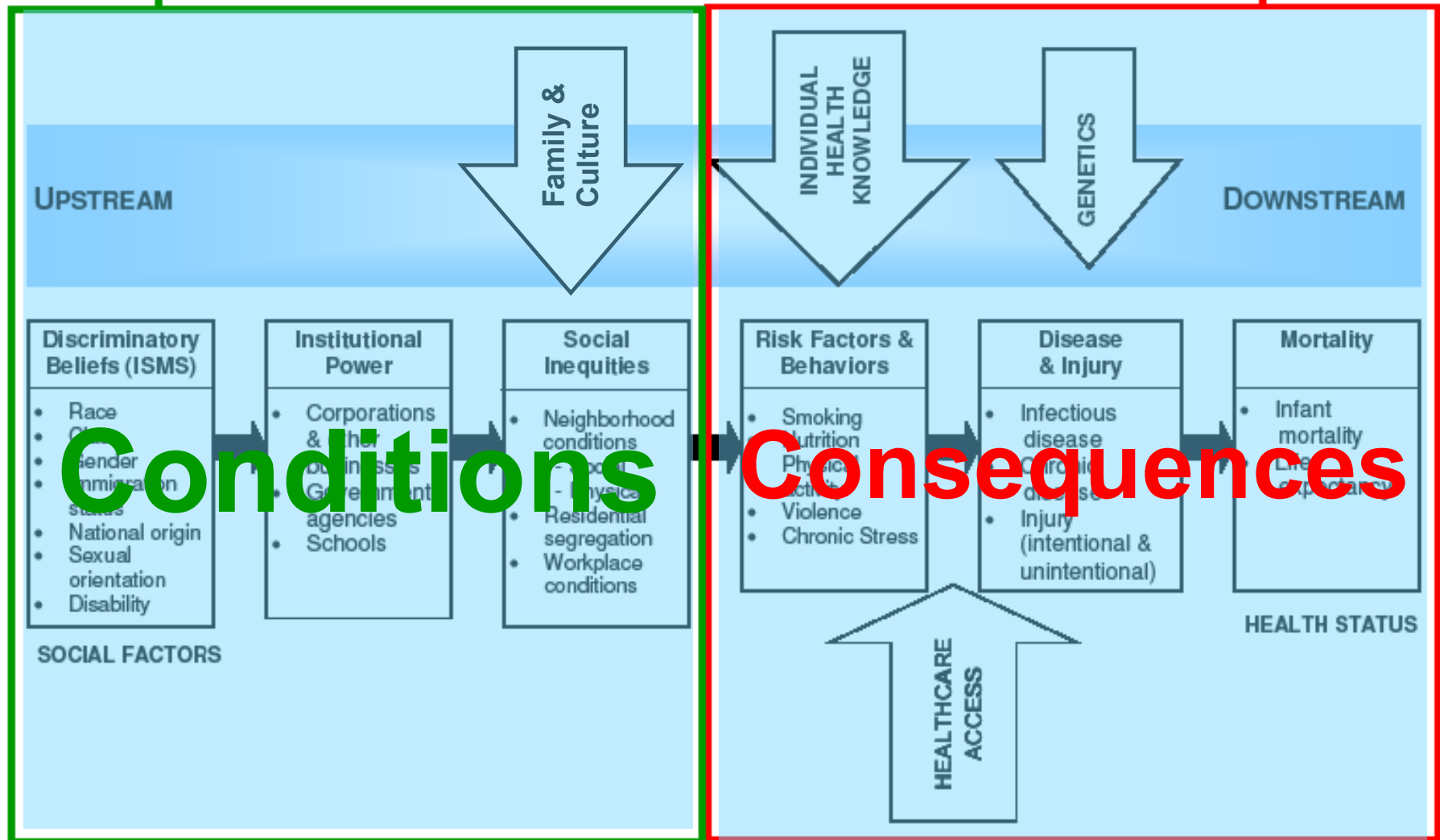


- Adapted by ACPHD from the Bay Area Regional Health Inequities Initiative, Summer 2008

A Framework for Health Equity

Socio-Ecological

Medical Model



Socio-Ecological (society)

Medical Model (individuals)



Change the Narrative

Policy Advocacy

Building Power in Place

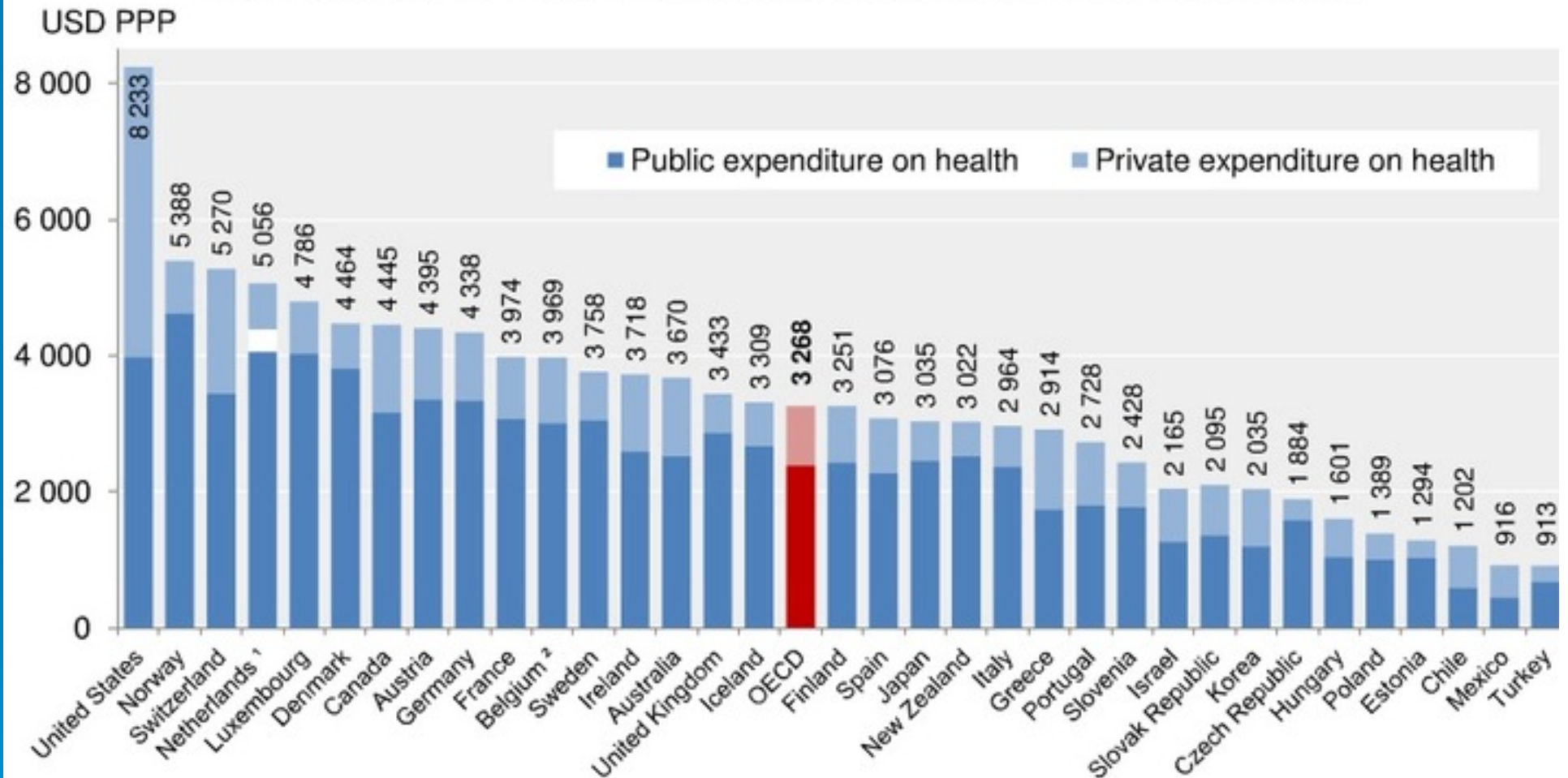
Health Education

Clinics

Emergency Rooms

US spends two-and-a-half times the OECD average

Total health expenditure per capita, public and private, 2010 (or nearest year)



1. In the Netherlands, it is not possible to clearly distinguish the public and private share related to investments.

2. Total expenditure excluding investments.

Information on data for Israel: <http://dx.doi.org/10.1787/888932315602>.

Source: OECD Health Data 2012.

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Contact Information

Tony Iton, MD, JD, MPH
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The Colorado Trust

together
WE BUILD A BRIGHTER FUTURE

November 15, 2013

Winston F. Wong, MD, MS

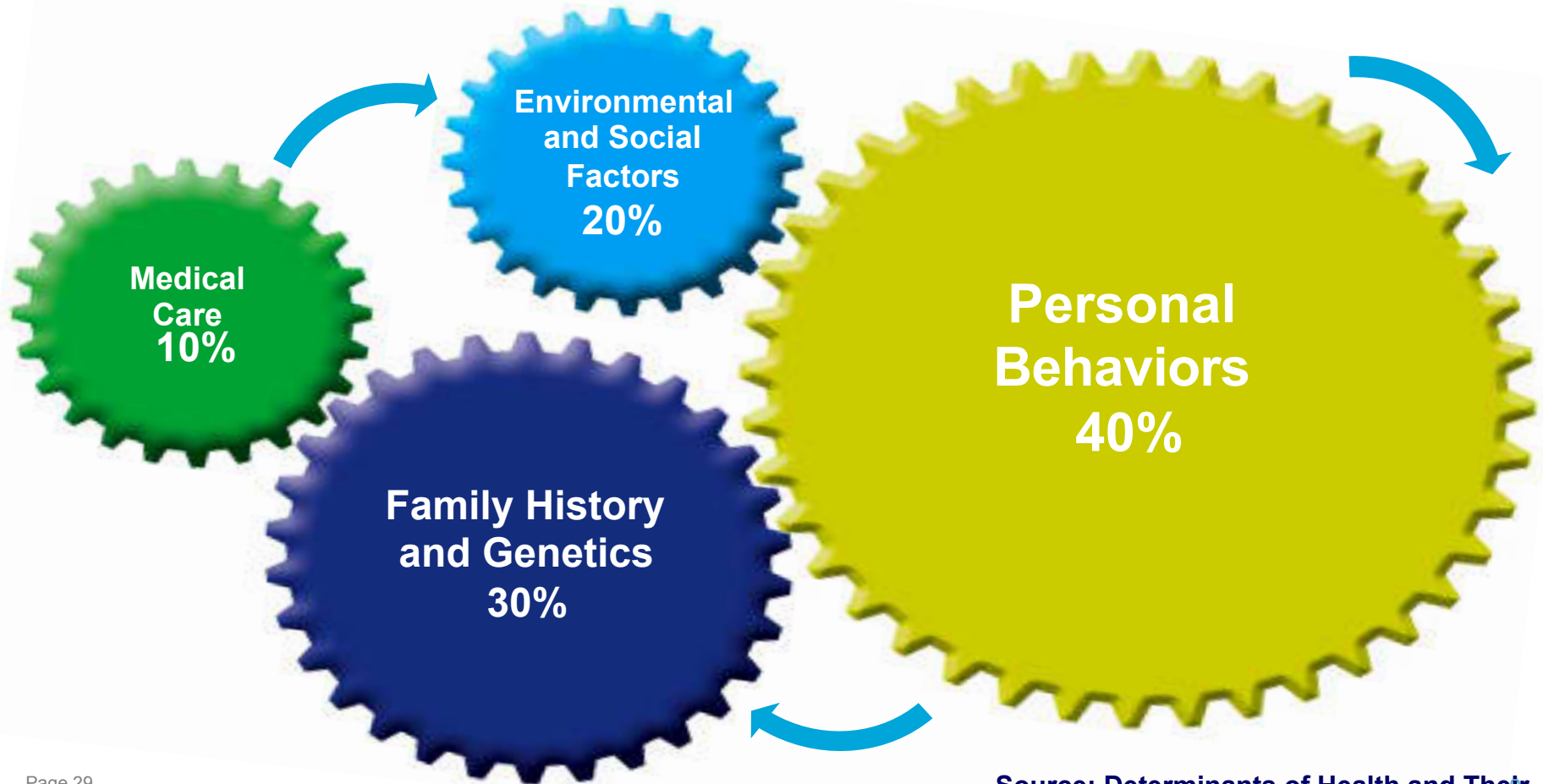
Medical Director, Community Benefit

Director, Disparities improvement and Quality Initiatives

Many Factors Shape Health

- Health is driven by multiple factors that are intricately linked – of which medical care is one component.

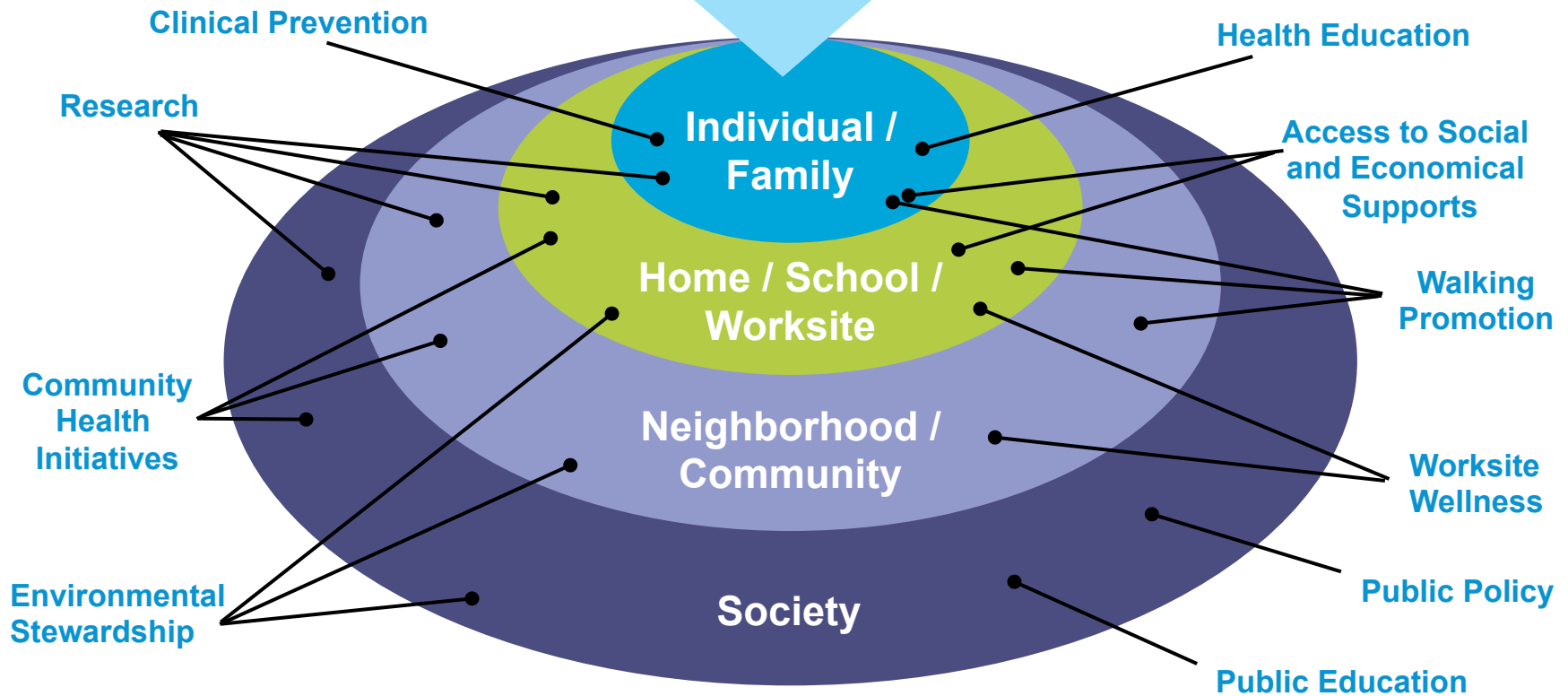
Drivers of Health



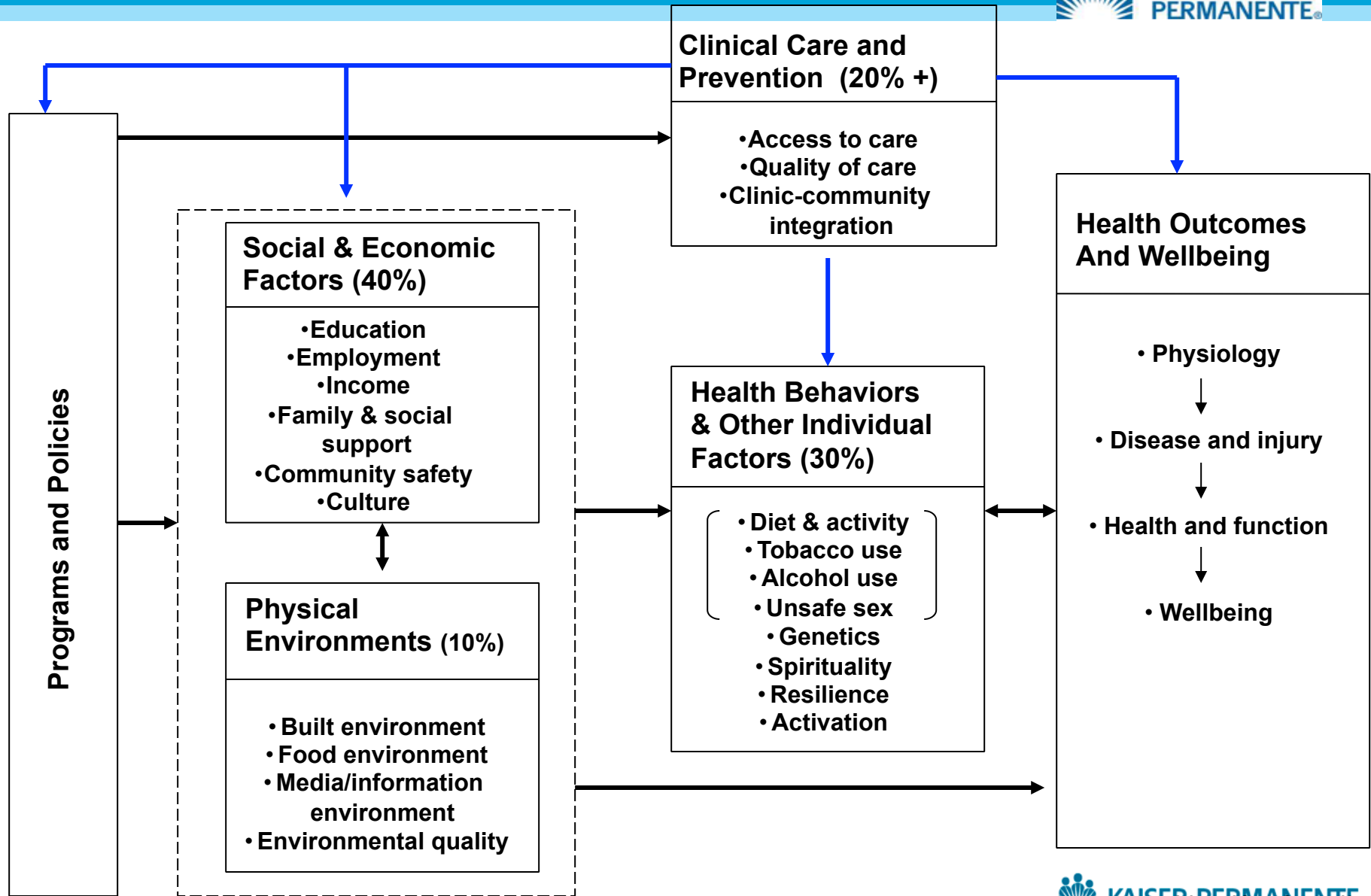
We Must Address Health At All Levels



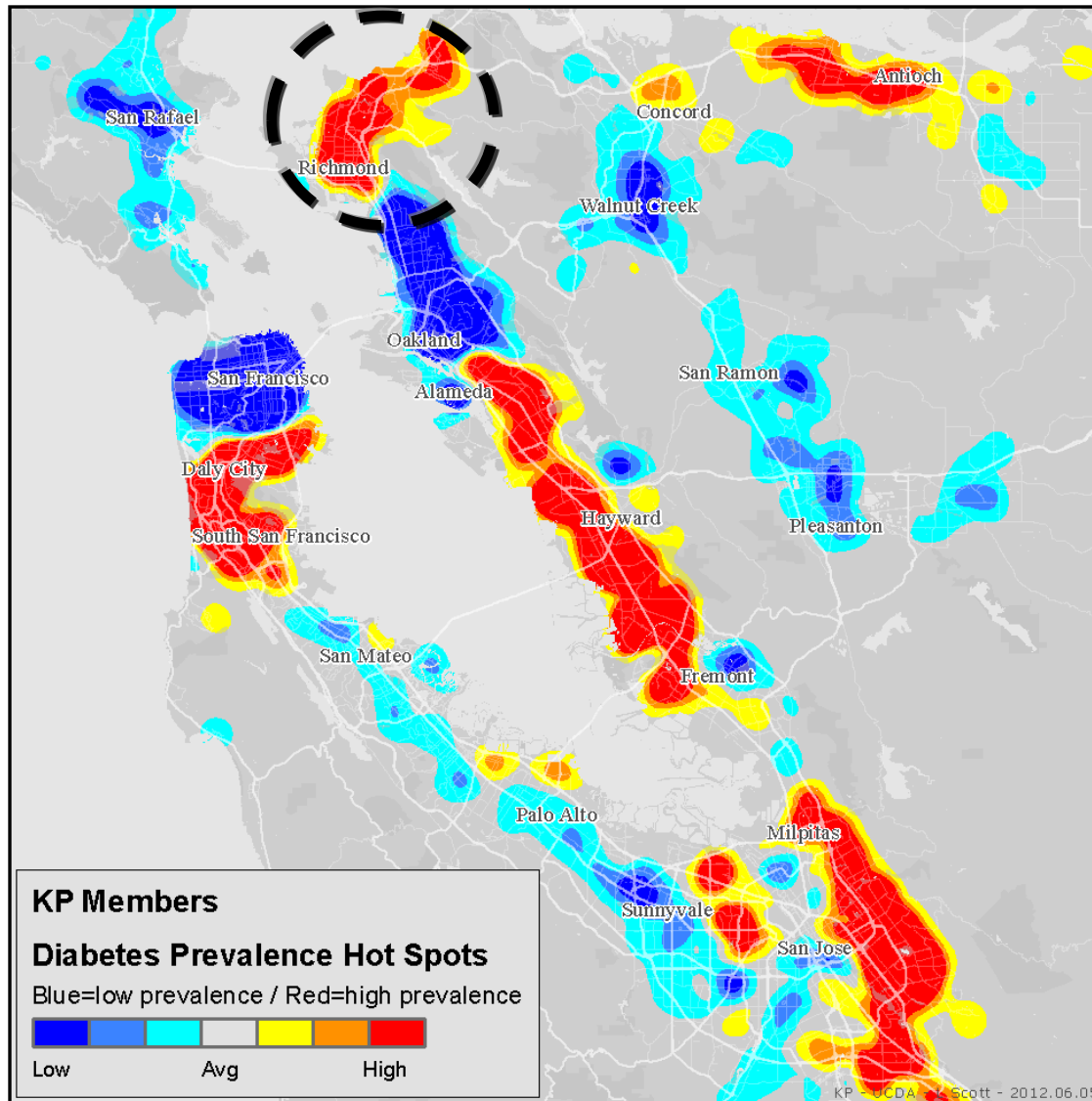
Physical and Mental Health Care



Total Health Framework



Data for clinical and public health



Richmond Area

- KP members have:
 - Some higher than average asthma prevalence
 - Higher hypertension prevalence
 - Higher obesity prevalence
 - Higher diabetes prevalence



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Join the discussion...

- Q & A from the audience
- Submit questions via Twitter:
#healthequityTCT



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✉ SIGN UP >

Google™ Custom Search

GO >



ABOUT US

PROGRAM AREAS

GRANTS

HEALTH POLICY

EVALUATION

PUBLICATIONS

NEWS & MEDIA

Health Equity

Our vision is that all Coloradans have fair and equal opportunities to lead healthy, productive lives regardless of race, ethnicity, income or where we live.

- > HEALTH EQUITY LEARNING SERIES
- > POLICY & ADVOCACY
- > DATA & INFORMATION
- > COMMUNITY-BASED GRANTMAKING



HEALTH EQUITY means ending inequalities that affect racial, ethnic low-income and other vulnerable populations, so that all Coloradans have fair opportunities to achieve good health.

GOOD HEALTH DEPENDS ON MORE THAN MEDICAL CARE. It is affected by where we live, the education we receive, the work we do, the wages we earn and by our opportunities to make decisions that improve our own and our family's health.

CommunityConnections BLOG

- > 11/13/13 Increasing Empathy to Improve Patient Outcomes
- > 11/04/13 Things Have (Slightly) Improved



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Feedback Survey November 15, 2013 Learning Lunch

Please take a moment to give us your feedback on the event today. Your responses will help us to plan future events like this one. You may leave your completed survey on the table before you leave.

- 1) What type of organization are you from?
 - Community organization
 - Policy/Advocacy organization
 - Direct service provider- Health
 - Research/Evaluation
 - Academic Institution/University
 - Government
 - Media
 - Business
 - Community member
 - Foundation
 - Other: _____
- 2) What is the primary reason you chose to attend this event today?
 - The topic was of interest to me
 - The speaker was of interest to me
 - Networking with community members
 - My relationship with The Colorado Trust
 - I'm here for the free lunch
 - Other: _____
- 3) How relevant did you find the topic discussed today to your work?
 - Highly relevant
 - Somewhat relevant
 - Neither relevant or irrelevant
 - Not very relevant
 - Not at all relevant
- 6) Are you interested in attending future events like this?
 - Yes No *Why not?* _____
 - If yes, I would prefer to attend:*
 - In person Stream online I would like to have both options
- 7) After attending this event today, do you feel more inclined to take action to promote health equity?
 - Yes No
 - If not, why not?*
 - I already take action to promote health equity in my work; this has not changed
 - It is not a high priority for me/my work, but I hope that others address it
 - I do not feel that it is an important issue to address
 - Other: _____
- 8) Will you take any action based on this event?
 - I will take the discussion materials provided by The Trust back to my organization
 - I will share the recording of this event with others in my organization (*available shortly on The Trust's website*)
 - I will encourage others to attend future events like this one
 - Other: _____
 - It is unlikely that I will take any action
- 9) Prior to this event, were you aware of the option to stream this event online?
 - Yes No
- 10) Please rate your level of satisfaction with the following:



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Thank you for joining us!