CLASP
Policy solutions that work for low-income people

Memorandum

To: Ming Wang, Program Administrator, Utah Department of Human Services
From: PATH Team at CLASP
Date: September 28, 2020
Re: Addressing Health Inequities

SUMMARY

COVID-19's disparate impact on communities of color has shed a light on persistent health inequities. Utah has stark health inequities across many indicators. Uninsured rates in Utah vary widely by race and ethnicity. While 12.7 percent of all Utahns don't have health insurance, 32.7 percent of Hispanic/LatinX Utahns don't have insurance and 21.5 percent of American Indian/Alaska Native Utahns don't have insurance.[1] There are significant physical and behavioral health inequities across racial and ethnic groups. For example, Asian American, Native Hawaiian and Pacific Islander Utahns (AAs and NHPIs) have a high incidence of lung cancer, breast cancer, and prostate cancer. The incidence rate per 100,000 of lung cancer among all Utahns is 29.7, while it is 31.5 among AA and NHPI Utahns.[2] The diabetes prevalence (2011-2013) among all Utah adults was 7.4 percent, but was nearly 16 percent for NHPI Utahns, 13.3 percent for American Indian/Alaska Native Utahns, and 12 percent for Black/African American Utahns.[3]

In terms of behavioral health, Hispanic young people in Utah (grades 9-12) have a higher incidence of suicide attempts than white young people (10.2 percent compared to 6.2 percent).[4] 15.8 percent of all Utah adults (2011-2013) had a poor mental health status, defined as seven or more days in the past thirty days when mental health was "not good." However, the percentage for American Indian/Alaska Native Utahns was 20 percent.

In terms of maternal health, 74.2 percent of all Utah infants received first trimester prenatal care (2009-2013), but only 42.1 percent of Native Hawaiian/Pacific Islander Utahns infants received first trimester prenatal care, and the rate of infant deaths per 1,000 live births for this group is 8.9, compared to the rate for all Utahns of 4.9. The infant mortality rate among Black/African American Utahns is 10.5 per 1,000 live births.[5]

These statistics are likely underreported due to dataset and data collection limitations, including the lack of disaggregated data. Additionally, underreporting occurs if people don't trust the surveys and the data is self-reported.[6]

This memo overviews broad policy solutions that can help to reduce both physical and mental health inequities, focusing on holistic interventions that can work to eliminate inequities across physical, mental, and maternal health.

Overview

SAMHSA defines behavioral health equity as "the right to access quality health care for all populations regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location. This includes access to prevention, treatment, and recovery services for mental and substance use disorders."[7] SAMHSA notes that advancing health equity requires addressing the social determinants of health.

The cultural and structural barriers that produce health inequities differ among populations. For example, American Indian and Alaska Native (AI/AN) children and adolescents have the highest rates of lifetime major depressive episodes and the highest self-reported depressions rates among all ethnic/racial groups. Additionally, in 2014 suicide was the second leading cause of death for AI/AN individuals between the ages of 10 and 34 and was the leading cause of death for AI/AN girls ages 10-14. Key barriers for this group include economic barriers, lack of culturally sensitive mental health services, mistrust of healthcare providers, and lack of appropriate intervention strategies.[8]

Additional racial and ethnic inequities in access to behavioral and primary health care persist across racial and ethnic groups. Particularly, Black and Hispanic people have substantially lower access to mental health and substance-use treatment services. In 2018, 69.4 percent of African Americans over age 18 with any mental illness (AMI) did not receive treatment. Among Hispanic Americans living with AMI (age 18+), 67.1 percent did not receive treatment. These groups also have limited access to prevention, treatment, and recovery services for substance use disorders.[9] Asian American and Pacific Islander individuals are also less likely to receive substance abuse treatment, when they need it.[10] Those with limited English proficiency are less likely to use primary care services than fluent speakers, and neighborhoods with a higher incidence of crime are less likely to have convenient primary care services.[11]

Culturally Responsive Healthcare

One key strategy to reduce health inequities across populations is to improve access to culturally responsive healthcare. The following policies can improve access to culturally responsive care and can help to reduce health inequities:

- Diversify the behavioral health workforce
- Increase funding and training for cultural and linguistic responsiveness for providers
- Build strong relationships and programs within ethnic and racial minority communities

Fast-tracking immigrant, refugee, and bilingual health care professionals who have been closed out of the health profession would create a pool of over 200,000 potential health care workers.[12] Data disaggregation by race and ethnicity at the local level can help target resources.[13] Language translation, culturally tailored messages, and trusted messengers like faith-based leaders and CBOs can help build community relationships. Positions like Community Health Workers and peer navigators are also critical for outreach.[14]

<u>Access: COVID-19 and Telehealth</u>

While COVID has both highlighted and worsened existing health inequities, many policies enacted due to COVID-19 have the potential to reduce health inequities if fully implemented and made permanent. For example, most insurers have at least temporarily enhanced coverage for telehealth visits, and HIPAA compliance has been relaxed. While there is still a digital divide in Black and LatinX households, telehealth does make both physical and behavioral health care more accessible for communities of color and low-income communities by eliminating barriers such as transportation and childcare. Because most outpatient clinics, CBOs, and urgent care centers have adapted to telehealth due to COVID-19, they have greater capacity to use telehealth if COVID-19 policy changes were to be made permanent.

Targeted Support: Maryland – Health Enterprise Zones

In 2013, Maryland launched the Health Enterprise Zone Initiative. Health Enterprise Zones (HEZs) are areas with documented health disparities and poor health outcomes. The four-year pilot program with a budget of $4 million per year offers incentives to these zones that can be used to address inequities. These incentives included loan repayment assistance for healthcare workers in these zones, income tax credits, priority to enter the Maryland Patient Centered Medical Home Program, grant funding from the Community Health Resources Commission (CHRC), and priority for receiving funds for establishing an electronic health records program.[15] HEZs worked to expand and diversify the health workforce in communities with high levels of health disparities. John Hopkins Bloomberg School of Public Health conducted a study on the impacts of HEZ. According to their findings, there was a decline of more than 18,000 inpatient stays over the course of the four years and an overall care cost reduction of around $93 million. Rep. Anthony Brown (MD-4) introduced the Health Enterprise Zone Act (HEZ) Act of 2020 to scale up this idea.[16]

The Social Determinants of Health: Upstream Solutions

Because many health inequities are the result of disinvestments in communities of color, upstream solutions that address the social determinants of health help to reduce health inequities. SDOH are factors linked to both physical and mental health outcomes, including economic stability, education, social and community context, health and health care, neighborhood, and built environment.

Addressing socioeconomic inequities can help to address health inequities. Income inequality is associated with higher health care expenditures, health care use, and death from cardiovascular disease and suicide.[17] Policies that increase financial security predict improvements in maternal, physical, and mental health. [18] These policies include:

- More generous EITC benefits
- Raising the minimum wage
- Expanding Paid Family and Medical Leave
- Expanding unemployment insurance
- Policies that increase access to food, housing, and other services like childcare

Policies that impact built environment can also help to reduce health inequities. Access to clean air and water are critical to maintaining good health, as are access to parks and recreation areas. Policies that impact built environment and improve community health include:

- Designing walkable neighborhoods
- Designing complete streets, which are streets designed to enable safe access for all users, including pedestrians, bicyclists, motorists, and transit riders of all ages and abilities[19]
- Using mixed-use zoning[20]
- Access to low-cost or free transportation that can help facilitate access to other needed resources like food, employment, education, and health care[21]
- Ensuring that all infrastructure projects conduct a racial equity analysis and don't exacerbate environmental racism

Finally, policies that improve access to care and reduce the cost of care help to reduce health inequities.

These policies include:

- Medicaid expansion
- Pay-for-performance models
- Bundled payments
- Integrated physical and behavioral health care
- Value-based payments

Ideally, sectors can work together to address health inequities. For example, Medicaid enrollees could be given housing support and help navigating the public benefits system.

Cross-Sector Collaboration: California – "Health in All Policies"[22]

Health in all Policies came out of a project in California. The project embedded health considerations into decision-making processes across a broad array of sectors to ensure a collaborative approach to health. The governor issued an executive order providing high-level support for health in all policies and a task force engaged non-governmental stakeholders and representatives of local government. The taskforce was particularly focused on connections between health outcomes and greenhouse gas reductions. They developed aspirational goals, created criteria for the selection of recommendations, and wrote a report with thirty-four recommendations. Recommendations spanned six topic areas, each encompassing SDOH:

- Active transportation;
- Housing and indoor spaces;
- Parks, urban greening, and places to be active;
- Community safety through violence prevention;
- Healthy food;
- Healthy public policy.

The taskforce then worked towards prioritizing and implementing those recommendations, convening and consulting multiple stakeholders.

One of the biggest successes of the project was a cultural shift among state agencies, including a higher level of interest in intersectional collaboration. They also saw a number of concrete changes in state policy and programs. For example, the Department of Finance, Department of Education, Department of Food and Agriculture, and the California Department of Public Health (CDPH) all provided resources to create the interagency Office of Farm to Fork. The office promoted policies and strategies to improve access to healthy, affordable food. The Governor's Office of Planning and Research also worked with CDPH to identify land use strategies to expand the availability of affordable, locally grown produce. The program also encouraged regional entities to apply for funding to incorporate health into their planning and decision-making processes and to partner with local health agencies.

Incentivizing Equity: Connecticut – State Innovations Model[23]

Connecticut was a round two model test state through The Center for Medicare and Medicaid Innovation (CMMI) Social Innovation Models (SIM) program. The program awarded funds to eleven states to use policy and regulatory levers to enable or facilitate the spread of innovative health care models. One of Connecticut's goals was to improve equity. The state created a population health plan focused on fostering coordination and accountability between community organizations, health care providers, schools, and other entities. The plan aimed to reduce inequities by improving health and social determinants of health. Among

other ideas, the plan called for TA to help Advance Networks and FQHCs improve their support for individuals with complex needs, reduce health equity gaps, and integrate behavioral and oral health. They also created Person-Centered Medical Home Plus (PCMH+). The PCMH+ model rewards providers in Advance Networks or FQHCs with shared savings for improving access, care coordination, health outcomes, and health equity. Connecticut also encouraged value-based insurance design and focused on growing the community health worker (CHWs) workforce and integrating CHWs into primary care teams.

Innovative Medicaid Financing: Oregon – Coordinated Care Organizations[24]
In Oregon, Coordinated Care Organizations (CCOs) have been the main vehicle for transforming service delivery to Medicaid recipients since 2012. CCOs coordinate care across a range of health domains, including supports for physical health, public health, mental health, substance abuse, and transportation. CCOs reflect Oregon's efforts to truly transform health care delivery, to push the boundaries of health care, and to innovate around what the effective integration of physical and behavioral health care can mean for a range of outcomes. Oregon's approved 1115 Waiver currently allows CCOs to bill for "health-related services" that address social determinants of health such as food, housing, or employment support. The Oregon Health Authority is developing additional guidance for CCOs about how to best implement these programs to reduce costs and support better health outcomes. The Medicaid Advisory Committee completed guidance for housing in 2018 and engaged stakeholders for feedback.

The Impact of Systemic Racism on Health Outcomes

Systemic and persistent racism and discrimination lead to poorer health outcomes.[25] These health inequities are the result of centuries of public policies that have worked to place Black Americans "into places that incubate illness"[26] while simultaneously blocking their access to healthcare. Black people are disproportionately exposed to environmental threats like air pollution and lead poisoning, which produce corresponding physical and behavioral health problems, like asthma. Concurrently, they have less access to resources like pharmacies, hospitals, and quality food. [27]

Mass incarceration also poses considerable health risks for all justice-impacted individuals and communities. Due to racial inequities in policing and criminal justice systems, reforms to the justice system would disproportionately improve health outcomes for people of color. Additionally, people with mental illnesses are overrepresented in the criminal justice system. Nearly half of the people in jail have been told by a mental health professional they have a mental illness. However, people of color are less likely to receive needed mental health care once incarcerated. [28] Policies like alternative sentencing strategies, family preservation, and reentry programs can help to reduce health inequities.[29]

However, to address the root cause of these inequities, policies focused on minimizing justice-system involvement, like policies that address the school-to-prison-pipeline, and policies that ensure the justice system is not the first touchpoint for mental health services, like mobile crisis, are effective.

Replacing police in schools with mental health counselors could help to improve health outcomes for young people of color. Seventy percent of children who receive mental health services access those services at school.[30] Many access mental health services at school-based health centers (SBHCs) which help to bolster access to both physical and mental health care for young people. SBHCs lower the cost of health care and research done on SBHCs in Cincinnati suggest that SBHCs help to close health care disparity gaps.[31]

While mental health professionals on campus can help to improve overall school safety while improving academic achievement, increased police presence in schools has the opposite effect.[32] Therefore, these actions should be taken in tandem: schools should remove law enforcement from campus and reinvest those

resources in mental health professionals. Utah does not meet the recommended student-to-counselor ratio of 250:1 with a ratio of 663:1. It likewise falls way below the recommend student-to-nurse ratio of 750:1 with a ratio of 4479:1.[33] Because many mental health needs emerge during adolescence[34], bolstering mental health supports in schools could be instrumental to reducing health inequities long-term.

In general, eliminating racist policies helps to reduce health inequities. For example, data showed that life expectancy and infant mortality improved for Black Americans after Jim Crow laws and redlining were reduced.[35] Further, when the racial economic gap between Black Americans and white Americans was narrowed from 1968 to 1978, health inequities for Black Americans also decreased. This trend reversed when the economic gap widened again in the 1980s.[36]

Addressing Racial Inequity: San Francisco, CA -- The Abundant Birth Project[37]

On September 14, 2020 the mayor of San Francisco announced the launch of the Abundant Birth Project. This pilot program provides targeted basic income to pregnant Black and Pacific Islander women. The project aims to reduce maternal health inequity. In San Francisco, Black babies are twice as likely to be premature compared to white babies, and prematurity can lead to lifelong physical and behavioral health consequences. Pacific Islander babies have the second highest preterm birth rate. Black and Pacific Islander women and babies also face inequities in maternal deaths and infant deaths.

The pilot program will begin by giving 150 women $1,000 per month for the duration of their pregnancies and for the first six months of baby's life. The ultimate goal is to provide support for up to two years post-pregnancy. The program is aimed at reducing financial insecurity while also affirming trust in women and their financial choices.

The city will work with local prenatal care providers and a network of pregnancy support services to identify and enroll clients. The community was involved in every phase of development, and Black and Pacific Islander women were part of the design team, trained community researchers, and engaged women with children to obtain accurate data of on-the-ground needs.

Conclusion

COVID-19's disproportionate impact on communities of color has highlighted how historical disinvestments in communities of color have impacted the health and wellbeing of those communities. Rectifying this inequity requires both changes to healthcare systems by making them more accessible, culturally responsive, and affordable, and looking beyond these systems to upstream factors that impact physical and mental health. Policy options that Utah can consider include:

- Make COVID-19 related changes to telehealth regulations and reimbursement policy permanent
- Provide incentives to providers to serve communities with high rates of health inequities such as loan forgiveness, tax incentives, and grant funding priority
- Improve the capacity of the health care system to address social determinants of health through integrated care models and care coordination
- "Health in all" policies that increase access to healthy food in communities and improve the built environment
- Directly target historic inequity and discrimination with targeted universal basic income and other economic policy improvements
- Prioritize health disparity reduction as an outcome measure in programs, policies, and health systems

Looking at health inequities in this holistic way allows states and localities to reduce health inequities across the board, encompassing both physical and mental health, rather than focusing on specific conditions and

targeted interventions while failing to change the underlying context.

Resources

- Racial and Ethnic Approaches to Community Health (REACH)
- Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE)
- SAMHSA Behavioral Health Equity
- State efforts to measure SDOH
- Utah: Cancer and Asian American, Native Hawaiians, and Pacific Islanders
- Beyond Health Care: The Role of Social Determinants of Health in Promoting Health and Equity
- Between the Lines: Understanding our Country's Racialized Response to the Opioid Overdose Epidemic

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