Oklahoma Task Force to
Eliminate Health Disparities

FINAL REPORT · JULY 2006

Oklahoma Task Force to Eliminate Health Disparities

Final Report ● July 2006

Table of Contents

Oklahoma Task Force to Eliminate Health Disparities Members

Claudia Barajas, Latino Agency Community Development Center

Sen. Bernest Cain, Oklahoma State Senate

Dr. Nancy Chu, University of Oklahoma, College of Nursing

Dorothy Gourley, Consultant Pharmacist

Annette Johnson, Sickle Cell Department, Children's Hospital

Dr. Sohail Khan, Cherokee Nation Health Services

Carter Anthony McBride, Retired, Pharmaceutical Industry

Tim O'Connor, Director, Catholic Charities

Sen. Constance N. Johnson, Oklahoma State Senate

Maria Palacios, Community Service Council of Greater Tulsa

Mike Parkhurst, Guymon Public School

Chester Phyffer, Pastor, Christ United Methodist Church

Brad Stanton, Community Health Center Consultant

Rep. Opio Toure, Oklahoma House of Representatives

Jean Wood, Oklahoma Department of Mental Health and Substance Abuse Services

Executive Summary

In 2003 Senate Bill 680 created the Oklahoma Task Force to Eliminate Health Disparities. Initially, twelve members representing the Oklahoma Legislature and diverse members of Oklahoma's population made up the Task Force. The Governor, President Pro Tempore of the Senate, Speaker of the House of Representatives, and the State Commissioner of Health each made three appointments. In 2004 an amendment to Senate Bill 680 added three new members to represent mental health concerns. The Task Force was charged to assist the State Department of Health investigate issues related to health disparities and health access (e.g., availability of health care providers, cultural competency, and behaviors that lead to poor health) among multicultural, underserved and regional populations; develop short-term and long-term strategies to eliminate health disparities, focusing on cardiovascular disease, infant mortality, diabetes, cancer and other leading causes of death; publish a report on the findings and recommendations for implementing targeted programs to move Oklahoma closer to a *state of health* through the reduction and eventual elimination of health disparities.

Health status in Oklahoma continues to decline. Since the late 1980s, Oklahoma is the only state in the nation in which age-adjusted death rates have been increasing. Over the past several years, the *State of the State's Health Report* has underscored the state's unacceptable health status. Oklahoma continues to have some of the highest rates of heart disease, diabetes, cancer, and other chronic health conditions. The reasons for Oklahoma's poor health status are complex and multi-faceted. Many Oklahomans lack health insurance and cannot afford the cost of adequate health care. A significant decrease in chronic health conditions would result from improving poor health behaviors. Simply put, we need to adopt healthy lifestyle choices: eat better, exercise more and avoid tobacco use. However, the disparity evident in population groups for certain diseases, health outcomes and access to health care is one of the most critical factors that accounts for Oklahoma's poor health status.

Three subcommittees were formed to tackle the complex multi-cultural, and economic issues associated with health disparities: 1) Cultural Competency; 2) Enhanced

Data Capacity; and 3) Health Access. Significant recommendations of the subcommittees are summarized below:

Cultural Competency Subcommittee

- Deliver cultural competency training to both healthcare providers and the institutions through which they provide services, including addressing the prevalence of emotional and physical violence in communities. Language barriers should be eliminated between healthcare providers and healthcare recipients, and culturally competent language assistance should be provided for limited English proficiency (LEP) populations.

Data Subcommittee

- Build a standardized statewide, integrated data collection and analysis system that meets all current Health Insurance Portability and Accountability Act (HIPAA) standards and state laws. Developing such a data system will lay the foundation for clearly identifying health disparities in Oklahoma and serve as the main tool to evaluate the effectiveness of interventions designed to eliminate health disparities.

Health Care Access Subcommittee

- Develop collaborative partnerships between communities and federal, state and local agencies to work on key cultural and communication barriers that impact health access and health education. One such partnership effort is Oklahoma Turning Point, which has been endorsed by the Oklahoma State Board of Health as a vehicle for systems change – improving overall health status in Oklahoma. Other key issues include supporting the development of training programs that expand the number of minorities among mental health and substance abuse professionals, administrators and policymakers; and provide intensive public awareness to policy makers and health improvement partners on the need to insure access to health care in order to reduce the burden of poor health status experience by Oklahoma's ethnic and minorities populations.

Introduction

As the *State of the State's Health Report* has underscored over the past several years, Oklahoma's health status remains unacceptable. The state continues to have some of the highest rates of heart disease, diabetes, cancer, and other health conditions. More important, since the late1980s, Oklahoma has been the only state in nation in which age adjusted death rates have actually been increasing. The reasons for Oklahoma's poor health status are multi-faceted. Economics no doubt play a role, as many Oklahomans simply cannot afford adequate health care or preventive services. Improving our poor health habits could contribute to a decrease in the development of chronic health conditions. Simply put, we need to adopt healthy lifestyle behaviors: eat better, exercise more, and avoid tobacco use. One of the most critical factors that accounts for Oklahoma's poor health status, though, is the disparity seen in population groups for certain diseases, health outcomes and access to health care.

This report translates the work of the Oklahoma Task Force to Eliminate Health Disparities, and makes recommendations on action steps to move Oklahoma closer to a state of health through the reduction and eventual elimination of health disparities. The Task Force, created in 2003 by Senate Bill 680, was charged to assist the State Department of Health to:

- Investigate issues related to disparities in health and health access among multicultural, underserved, and regional populations. These issues include, availability of health care providers, cultural competency, and behaviors that lead to poor health status.
- Develop short-term and long-term strategies to eliminate health disparities, focusing on cardiovascular disease, infant mortality, diabetes, cancer and other leading causes of death.
- Publish a report on the findings and make recommendations for implementing targeted programs for the elimination of health disparities.

The Task Force originally consisted of twelve members representing the Oklahoma Legislature and diverse members of Oklahoma's population. Three appointments were made each by the Governor, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the State Commissioner of Health. In 2004 an amendment to SB 680 added three new members who represented mental health concerns.

Members quickly realized that to make progress on the complex multi-cultural, and economic issues associated with health disparities, they would have to organize the work into subcommittees. These subcommittees included cultural competency, data, and health access, and are briefly described below.

Cultural Competency

A critical issue identified that affects health disparities is cultural competency. Being culturally competent potentially improves care and may aid in reducing the burden of health disparities. Cultural competency training should take place in agencies and health care settings. In addition, cultural competency training should be a standard curriculum component for health career students. Eventually, the goal should be to celebrate our diversity, treating people equally, and ultimately eliminating disparities in health care.

Enhanced Data Capacity

A prerequisite for effectively resolving health disparities is to identify what specific disparities exist through the careful analysis of data. Therefore, enhancing data capacity and identifying data resources that clearly define disparities among population groups are musts. Ideally, we should be able to link data from other agencies – creating a clearinghouse of reliable health-related data for the state of Oklahoma. This will help us to better understand what is happening today in order to improve the health status of tomorrow.

Health Access

As cited by the Oklahoma State Board of Health, one crucial action that can have a direct impact on reducing health disparities is increasing opportunities for health access among minority population groups.[1] This can be done in a number of innovative ways including reducing disparities in funding for health among minority population groups, increasing the number of minority health care providers in all areas by working in creative ways with universities and colleges to recruit and retain more minority students in health care training programs, and by working with community partnerships for the development of community health centers and voluntary health clinics.

These three areas, cultural competency, data, and health access, form the foundation of the recommendations from the Oklahoma Task Force to Eliminate Health Disparities. The remainder of this report provides a brief overview of identified health disparities in Oklahoma, followed by the recommendations from each subcommittee.

Health Disparities in Oklahoma

A number of data reports were prepared by the Data Subcommittee of the Task Force, and are attached as appendices. However, some specific disparities were identified and are summarized below:

- Native Americans smoke at higher rates (34.9%) than the rest of the Oklahoma population, followed by African Americans (31.8%), Whites (23.4%), and Hispanics (17.3%). (2004 BRFSS)
- African American women are almost twice as likely to die from breast cancer compared to White women. (2004 Oklahoma Vital Statistics) This may be due to delayed diagnosis in African American women, resulting in a more advance stage of the disease before treatment is provided.
- African Americans are more likely to die from heart disease (345.3 deaths per 100,000 population) than Whites (293.1 deaths per 100,000 population). (2004 Oklahoma Vital Statistics)

- High rates of obesity are seen among Hispanics, Native Americans, and African Americans. (2003 BRFSS)
- Higher rates of diabetes exist among Native Americans (11.3%) and African Americans (9.5%) compared to Whites (6.6%). (2003 BRFSS)

As detailed in the attached data reports, multiple disparities exist in the health status, health access, and health care treatment of Oklahoma ethnic minority populations. However, disparities also exist for Oklahomans with less education and lower incomes, regardless of race and ethnicity. The work of the Oklahoma Task Force to Eliminate Health Disparities just begins to identify health disparities in Oklahoma, and perhaps leads to more questions than answers. Without question, though, the work of the Task Force draws attention to the desperate need for greater awareness and more sustained efforts to be directed toward eliminating health disparities in Oklahoma's diverse populations. With that basic fact established, the Oklahoma Task Force to Eliminate Health Disparities offers the following recommendations from the three Subcommittees. If fully implemented, these recommendations would contribute to significant progress toward eliminating health disparities in Oklahoma and eventually lead to a much improved health status for Oklahomans overall.

Findings and Recommendations from the Subcommittees

Cultural Competency Subcommittee

In a generic sense, the term *cultural competency* has come to mean having the sufficiency to serve the characteristics of a civilization.[2] And though specific characteristics of specific populations exist in many parts of Oklahoma, the concept, as it is applied to healthcare by this subcommittee, is not differentiated from one population (culture) to the next. In essence, this summary of the application brings attention to the challenges and opportunities that exist in both assessing and changing the healthcare provider industry's ability to adequately serve the diversity of populations comprising Oklahoma.

This summary reflects the findings of the Cultural Competency Subcommittee as it worked to meet its mission: *to develop recommendations to the Oklahoma State Departments of Health (OSDH) and Mental Health (OSDMH) regarding disparities in healthcare from the perspective of culture.* Working in harmony to identify and report their ideas, goals, and strategies relating to cultural aspects of healthcare, Subcommittee members derived this content over the course of several years and many meetings.

The synergy and focus of its members came about due to commonly held, core interests and principles: (1) the acceptance of the common goal to address *cultural competency* in healthcare delivery as it crosses racial and ethnic barriers; (2) strong, wise leadership; (3) the willingness of leaders to follow; and (4) respect, and the value of applying it to others in order to become culturally competent.

The overlay of culture to health and healthcare adds a dimension having both challenges and opportunities for stakeholders. The challenging side brings issues related to:

- Perceptions of fairness by populations that do not receive the kind of health service(s) that others receive;
- Concerns for the systemic costs of change and new delivery methods outside of traditional budgeting and board-directed service venues;
- Learning how to link with diverse populations that aren't necessarily mainstream Oklahomans, or who may not have the means to obtain healthcare;
- A general lack of awareness of the role that culture(s) play in the lives of many residents; and
- Changes in both personal behaviors, and "how" and "why" healthcare services are institutionalized and ultimately delivered through public and private systems.

The opportunities bring to the table the possibility to:

- Positively impact the health in populations that are growing in number and diversity in our State, or who are not now adequately represented or served by healthcare systems;

- Improve the awareness, confidence, and responsiveness to treatment and healthcare services outside of traditional institutional systems;
- Comply with federal initiatives and other health-related mandates; and
- Generally improve the health of everyone through collective efforts to serve those populations with limited or no healthcare.

Potential sources of disparities include: (1) *systems-level* inequities related to finances, structure, culture, and language; (2) *patient-level* preferences, including refusal of treatment, poor adherence to instructions, and biological differences; and (3) *situational* disparities within the clinical encounter, reflective of bias, prejudice, uncertainty, stereotyping, and distrust between provider and consumer. Demographic factors prefacing disparities include: race, gender, age; income; insurance status; rural or urban location; sexual orientation; housing status; and occupation or health behaviors.[3]

Examples of disparities include: African American men having a rate of prostate cancer double that of Caucasian men; Women of Vietnamese origin having cervical cancer at the rate of five times that of Caucasian women; Injury-related death rates being 40% higher in rural populations than in urban settings; Infant mortality rates of African American, American Indian and Alaska natives being double that of Caucasians.

The role of cultural competency involves five essential elements:

1. Valuing diversity;
2. Having the capacity for cultural self-assessment;
3. Being conscious of the dynamics inherent when cultures interact;
4. Having institutionalized cultural knowledge; and
5. Having developed adaptations of service delivery reflecting an understanding of cultural diversity.

With those concepts in mind, the subcommittee developed eight outcomes of interest (goals) having related approach strategies:

Goal 1: Cultural competency training should be delivered to both healthcare providers and the institutions through which they provide services, including addressing the prevalence of emotional and physical violence in communities.

Strategies:

- Require OSDH employees and contractors to take a minimum of 3 hours of cultural competency training that would complete the following model as specified by OSDH policy, or as applicable:
  - Awareness
  - Self-assessment
  - Dynamics of difference
  - Institutionalization
  - Change/adaptation
- Require OSDH to collaborate with licensure boards to mandate integration of cultural competency training into continuing educational unit (CEU) annual requirements.
- Require OSDH to collaborate with institutions of higher learning to increase the curriculum requirements for cultural competency training during internships, practicum, and clinical rotations.
- Encourage OSDH Board of Health members to embrace and promote competence and diversity by:
  - Recruiting minority members;
  - Attending 3 hours of cultural competency training annually;
  - Supporting and facilitating recommendations of the Health Disparities Task Force.

Goal 2: The trust and confidence that minority populations have in healthcare providers should be increased and improved.

Strategies:

- Strongly encourage members of the OSDH Board of Health to embrace, promote, and become proactive in:
  - Cultural competence
  - Cultural diversity
  - Eliminating health disparities, by creating and implementing an action plan and/or rules to address these issues.
- The members of the OSDH Board of Health should actively promote the involvement of professional associations in adopting such a plan or rules.
- The OSDH Board should be encouraged to add a Board member that represents cultural diversity, and utilize the Health Disparities Task Force Cultural Competency Subcommittee as an advisory committee.

Goal 3: Language barriers should be eliminated between healthcare providers and healthcare recipients, and culturally competent language assistance should be provided for limited English proficiency (LEP) populations.

Strategies:

- The OSDH shall provide its employees and contractors the tools, materials, and resources necessary for language assistance, including:
  - Electronic interpreter services;
  - A language line;
  - Certified medical interpreters, including for the hearing impaired population;
  - Use of a Review Committee for written (translated) items;
  - Accessing the language and cultural expertise that exists within local community and volunteer organizations (Latino United League of American Citizens, Latino Community Development Agency, etc.);
  - Convening educational training events (i.e., conversational Spanish, Vietnamese, Korean classes, or other specific language);
  - Assistance with technical matters;

- Software for translating materials;
- Website for LEP applications and uses, including Alta Vista and free translation;
- Modifying PHOCIS to ask for special accommodations and other assistance as needed.

Goal 4: Culturally appropriate health/wellness education for LEP populations should be developed and implemented through public schools and community-based efforts.

Strategies:

- The OSDH shall partner with: the State Departments of Education, Special Education, Mental Health/Substance Abuse, Human Services; and the Oklahoma School Board Association, Indian Health Services, Office of Juvenile Affairs, all Native American Indian Tribes, the Oklahoma Commission on Children and Youth, the Oklahoma Institute for Child Advocacy, the Oklahoma Turning Point Initiative, the Veterans Administration Medical Center, State Career Tech, NAACP, Parent Teachers Associations, and Parent Teacher Organizations, OU Health Sciences, OSU, all faith communities in Oklahoma, minority medical associations, Areawide Aging Agency services, Area Health Education Centers, Area Prevention Resource Centers, and others, to develop, train, implement, and evaluate culturally appropriate health and wellness education plans.

Goal 5: Bilingual and minority healthcare providers should be recruited and hired to reflect the populations being served.

Strategies:

- Provide education and assistance to include scholarships, grants, loans, loan forgiveness, reimbursements, etc., which will include work payback to participating community programs;

- Identify and network with recruiters who are culturally competent;
- Establish target numbers of bilingual and minority providers and staff, reflective of populations being served.

Goal 6: Recommend changes in the Task Force's goals to include other recommendations going to other groups and agencies.

Strategies:

- Recommend that the Task Force amend its goals and objectives to include applications to all agencies and organizations that contribute to the improvement of health and wellness of Oklahomans.

Goal 7: Identify a baseline of health and healthcare disparities.

Strategies:

- Begin efforts to identify and report health disparity baselines in all parts of the State in order to effectively measure progress from intervention strategies.

Goal 8: Mandate an annual "public health report card."

Strategies:

- Mandate an annual health report card, statewide, that responds to efforts and activities aimed at correcting or augmenting strategies, goals, and objectives within the subject area of health disparities, distributed to the Office of the Governor, all Cabinet Secretaries, the State Legislature, the media, the public, and all federal and state agencies, for the purpose of creating an open and accessible means of "seeing" and "reporting" findings and progress, and to recognize effective leadership and positive results.

Data Subcommittee

> "Health disparities will never disappear without compelling proof that they exist in the first place."[4]

This opening quote summarizes very succinctly the mission of the Data Subcommittee of the Oklahoma Task Force to Eliminate Health Disparities. Data that clearly illustrate health disparities among population groups are critical not only to make the case for intervention, but also to measure the effectiveness of interventions aimed at eliminating disparities. Although data does not necessarily translate into action or political will to make change, it nonetheless lays the foundation for change to indeed happen and make an impact. With compelling data as the foundation, it is then up to all of us to demand action from our legislative leaders, our government agencies, and our health care providers. With these thoughts in mind, the Data Subcommittee identified three major themes through its research and analysis.

First, disparities do exist in Oklahoma. Disparities exist in health access, health care coverage (health insurance), and appropriate treatment, often resulting in negative health outcomes. These identified disparities include but are not limited to, race and ethnicity, geographic location, age, gender, socio-economics (education, income level), education and language.

Second, health disparities occur in the context of broader historic and contemporary social and economic inequality, and possible discrimination in many sectors of Oklahoma life due to lack of understanding of cultural differences. While strides have been made in trying to eliminate health disparities, there is often a break within the health continuum between patients, various levels of healthcare (state and local), and policy, which creates disparities within population groups across the state of Oklahoma. This disconnect, may be caused by bias, stereotyping, and prejudice within the continuum of health care and may contribute to disparities in Oklahoma. Health care providers, at one end of the continuum of health care, may contribute to disparities in

Oklahoma. Patients, through lack of awareness, cultural beliefs and attitudes, at the other end of the continuum of health care, may contribute to disparities in Oklahoma.

Third, there is currently insufficient data, data collection systems, and resources to identify all of the factors that may contribute both directly and indirectly to health disparities in Oklahoma. As a result, it is difficult to identify all definite direct and indirect factors (barriers) that contribute to the break within the health continuum. Programs that seek to eliminate health disparities may be limited in meeting the essential needs of targeted populations because of insufficient data systems available to measure current disparities and evaluate the effectiveness of interventions.

The three major findings resulted in the Data Subcommittee developing three major sets of recommendations – general data recommendations, data collection and monitoring, and research needs:

General Data Recommendations

- Raise the awareness of health professionals, state, county and community leaders of the important issue of health disparities and the adverse impact to the state of Oklahoma.
- Support community-based activities to eliminate health disparities, and create greater accountability through such measures as diversifying governing boards and program staff.
- Foster appreciation of the diversity of Oklahoma by healthcare providers through education and continuing education credits.
- Enhance and assure that the statewide system of community referrals (211) includes free and reduced cost health services that can assist in reducing health disparities in Oklahoma.
- Standardize the definition of health *disparity* at the state level.

Data Collection and Monitoring

- Build a standardized statewide, integrated data collection and analysis system, that meets all current Health Insurance Portability and Accountability Act (HIPAA) standards and state laws.

- Collect and report data on health care access and utilization by patients' demographics (including but not limited to gender, race, ethnicity, socioeconomic status, geographic location, and primary language).
- Integrate disparities measures in ongoing quality improvement and monitor changes in racial and ethnic disparities in care over time. .
- Create systems to collect data on patient race and ethnicity that are consistent state and nationwide (including five minimum race codes and ethnicity as per OMB Directive 15).
- Provide funding and adequately trained staff to work with all appropriate state agencies and data collection sources and monitor progress toward the elimination of health disparities.
- Provide training, technical assistance and support to community programs to properly collect and analyze data on health disparities.
- Improve/encourage data linkage between state agencies and health providers to further evaluate the impact of health care services on outcomes and their link to disparities.
- Provide data on health disparities to organizations, agencies, and academic institutions that educate health care providers, administrators, policy makers, consumers, and the media.

Research Needs

- Support the program evaluation and research that identify best practices to reduce health disparities in Oklahoma.
- Research on health and disease must be interdisciplinary, encompass multiple levels of analysis, integrate across all levels of health care, and include the patient's perspective.
- Encourage disparities assessment related to socio-ecological factors (including but not limited to housing, environment, geography, and family).
- Focus on the factors underlying good health, as well as disease.
- Conduct research on ethical issues related to eliminating disparities.
- Develop better methods to link data sets.

- Provide opportunities for collaboration between and among state agencies, academic institutions, and private sectors to conduct research on eliminating health disparities in Oklahoma.

Although the Data Subcommittee feels that each of these recommendations is important, the first *key* recommendation that should be accomplished is to build a standardized statewide, integrated data collection and analysis system, that meets all current HIPPA standards and state laws. Such a system was proposed legislatively during the 2006 Oklahoma Legislature (SB 1636); however, the bill was not heard on the House Floor. Consequently, the Data Subcommittee strongly urges the Oklahoma State Department of Health and the Oklahoma Department of Mental Health and Substance Abuse Services to collaborate and pilot an integrated health data system, which could eventually be expanded statewide. Developing such a data system will lay the foundation for clearly identifying health disparities in Oklahoma and serve as the main tool to evaluate the effectiveness of interventions designed to eliminate health disparities.

Health Care Access Subcommittee

The Health Care Access Subcommittee developed a list of recommendations to address the issue of health care access in the state. These recommendations were drafted: (1) in terms of identifying health care access needs for the state's underserved populations, including those representing Oklahoma's racial and ethnic minority communities; and (2) in consideration of recent and ongoing state efforts to address health care access through funding initiatives (e.g., Tobacco Tax and provider reimbursement), insurance coverage, community health centers, prescription drug access, breast and cervical cancer treatment, research, trauma care and state Medicaid reform.

While the recommendations are designed for implementation by the Oklahoma State Department of Health (OSDH) and the Oklahoma State Department of Mental Health and Substance Abuse Services (ODMHSAS), the Subcommittee affirms that in reality, health care access is the responsibility for all committed to ensuring health care access for the state's populations. Therefore, establishing collaborative partnerships to

achieve health care access on behalf of those with the greatest health needs is a continuing priority for these two state agencies. Further, in looking at the larger picture, these recommendations are considered to be part of an evolving, ongoing process. Health care access, within the context of health disparities, is a challenging undertaking that requires long-term commitment and that should continue to be a high priority for the state beyond the existence of the Task Force. There are no easy answers. In consideration of these issues, the Subcommittee developed the following recommendations:

- Develop training programs to increase the number of minorities among mental health and substance abuse professionals, administrators and policymakers.
- Develop a centralized health disparities data link through the OSDH Web site to provide an easily accessible source of current, reliable information for health professionals, policymakers, researchers, students and the general public.
- Work with the University of Oklahoma College of Public Health (OU COPH) and the University of Oklahoma College of Medicine to increase the number of minorities in the health professions, (e.g., physicians, nurses, health educators, epidemiologists, environmentalists, etc.).
- Develop an ongoing preventive health education and awareness campaign involving the OSDH, ODMHSAS, Office of the Governor, legislative officials, and other partners to draw attention to health disparity issues through the assurance of health care access. This would include activities such as, radio and television spots, newspapers, press releases, town-hall meetings, and other community forums. Faith-based organizations and schools may also participate in this awareness campaign.
- Develop collaborative partnerships between communities and federal, state and local agencies to work on key cultural and communication barriers that impact health access and health education.

Although not part of the recommendations, a variety of topics affecting health care access were also discussed and considered, including, but not limited to:

- Encouraging diversity training for state medical and health professionals;
- Increasing school-based clinics with sufficient staffing of nurses;
- Convening a state health disparities conference;
- Developing a health needs assessment for racial and ethnic populations at the county and local level;
- Decreasing utilization rates of emergency room care;
- Ensuring access through primary care by increasing the number of community health centers and providing adequate reimbursement for providers, hospitals and clinics; and
- Enhancing the capacity of the Oklahoma Turning Point initiative to address health disparities at the local "grass roots" level.

Although definitions vary, health care access is generally defined as the "timely" use of health services to achieve the *"best possible outcomes"* [5] including preventive care and ongoing care. Factors that impact health care access include insurance coverage, education, income, health care costs, language barriers, cultural beliefs and attitudes, provider location, service availability, transportation, etc. Health access is identified as both a leading health indicator and as a health objective of Healthy People 2010 ,[6]the Nation's health objectives for the 21st century. Locally, in its 2002 State of the State's Health Interim Report, Health Disparities: the haves & have-nots, the Oklahoma State Board of Health acknowledged the importance of health care access as a "positive" impact on health disparities.[7] The OSDH has also added *health care access* among its agency priorities.[8]

In a review of reports and through testimony, the Subcommittee found a variety of challenges at both the state and national level. Nationally, the proposed cuts in safety net programs such as Medicaid and Medicare;[9] the continuing trend of increasing numbers of uninsured persons, including immigrants;[10] the concerns regarding the escalating costs and affordability of health care;[11] and the reporting of disparities in treatment and access for minorities, including mental health,[12] all point to the difficulty in ensuring health care access for the nation's population, including the nation's vulnerable and underserved persons. Adding to these difficulties are perceptions concerning the seriousness of access

and health care – these too have proven to be significant issues that require appropriate attention. For example, a 2005 survey conducted on behalf of the Robert Wood Johnson Foundation found that 68 percent of Americans were "unaware" that racial and ethnic minorities receive poorer care than Whites, with the greatest lack of awareness among Whites.[13] However, the same survey reported that most of the respondents believed that all Americans deserve equal care.[14] Also, the Centers for Disease Control and Prevention point out that "unequal" access to care and unequal treatment of persons who receive care are "key determinants" of racial/ethnic disparities in health care and health status.[15]

In its review of health access in Oklahoma, the Subcommittee also found that the state is confronted by a variety of lingering issues that have significant impact the state's ability to develop health access reforms. These following factors contribute to the challenge of ensuring health care access : (1) developing minority health professionals, including African American and Hispanic medical school graduates and physicians;[16] (2) reducing the high percentage of uninsured persons in the state, most notably Hispanics at 40%;[17] (3) ensuring collaboration and communication between state policymakers and local community stakeholders with diverse cultural backgrounds; (4) developing cultural competence and cultural sensitivity among health professionals; (5) integrating mental health and primary care services; (6) developing accessible and accurate data to determine the extent of health access and health disparities issues both nationally and locally; (7) improving the socio-economic factors (i.e., education, income, economic development, etc.) contributing to the inability of persons and businesses to afford rising health care costs; (8) reducing the utilization of emergency rooms and trauma centers as a primary source of care; and (9) ensuring the availability of adequate services and resources (i.e., physicians, transportation, community health centers, etc.) in communities with the greatest health needs. For example, some of these issues are visibly highlighted in a 2006 report of the health care system in the Tulsa area, which generally finds it to be inadequate. The report further finds that access to health care would be greatly improved with the expansion of community health centers; school-based health clinics; the establishment of patient-referral linkages and the tracking of patient records.[18]

Access to health care has driven much of the recent health initiatives in the state, including state-subsidized insurance coverage, prescription drug access, provider

reimbursement, trauma care, breast and cervical cancer treatment and proposed reforms to the state Medicaid system. The tax on tobacco products recently passed by Oklahoma voters could be a major funding source to support many of these initiatives.

While much has been accomplished during the tenure of the Task Force, more work still needs to be done. Both the OSDH and ODMHSAS are encouraged to: (1) address health access and health disparities issues internally though strategic planning, reporting and collaboration; and (2) consistently collaborate with outside agencies and community partners such as the Oklahoma Health Care Authority, the Department of Human Services, the Oklahoma Primary Care Association, Central Oklahoma Project Access, Oklahoma Foundation for Medical Quality University of Oklahoma College of Public Health, various colleges, universities, medical schools, and hospitals . Traditional and "non-traditional" alliances are encouraged to advance new ideas and remove barriers to health access for those with the greatest health needs.

Recommendations

1. Support the development of training programs that expand the number of minorities among mental health and substance abuse professionals, administrators and policymakers.

   Rationale: As the general population increasingly becomes more culturally diverse, the incidence of mental health disorders among individuals from diverse racial and ethnic groups will also increase. Clinicians trained in traditional, Western biomedical psychiatry and other mental health professions will face new challenges in evaluating these individuals. Therefore, understanding of psychological functioning and mental disorders must be based on knowledge of these diverse groups.

   Strategy: Support the development of curricula of training and professional programs that explicitly encompass racial and cultural aspects and differences, which may affect access to, and effectiveness of, such programs. Conduct

evidence-based research to examine whether such training curricula and professional programs are effective. These curricula must be flexible enough to be updated regularly so that they can be inclusive of the expanding knowledge base.

2. Develop a centralized health disparities data link through OSDH Web site.

   Rationale: Intended to provide researchers, health professionals, students, and the general public access to a central source or clearinghouse of current, reliable information related to health disparities. Currently, persons seeking health disparities information must navigate their way through a complicated research process. This website would streamline that process.

   Strategy: With the OSDH Communications Service taking a lead role, develop a link of relevant health disparities information, including the Turning Point initiative, University of Oklahoma Health Science Center (OUHSC) research studies, Healthy People 2010, health disparities initiatives, funding opportunities, and calendar of events. A specific website that most closely resembles this is the Colorado Minority Health Forum, a Turning Point initiative.

3. Collaborate with the University of Oklahoma COPH and the University of Oklahoma College of Medicine to increase the number of minorities in the health professions.

   Rationale: Experts believe that having a greater percentage of racial and ethnic minorities in the health care field will help decrease culture and language barriers with the heath care system and help ensure more providers are available in ethnic and minority communities. By and large, physicians have not been trained to provide culturally competent care. This is a strategic starting point to address health disparities. “Cultural competence” education teaches medical/ health care providers how to more effectively address patients’ cultural beliefs and behaviors. Also, the medical system lacks prepared information that is culturally appropriate

(written, audio, video) to convey culturally sensitive messages in many Asian languages.

Strategy: Collaborate with the University of Oklahoma College of Public Health and University of Oklahoma College of Medicine to develop a pilot program that encourages minority institutions to train, recruit and retain talented minority undergraduate students in the biomedical and behavioral sciences. Offer scholarships and enhanced financing for medical school. Incorporate mandatory cultural competency training in the medical school curriculum (starting at undergraduate level prerequisites and continuous throughout medical school, internship, medical board exam, etc.) This would help ensure that cultural competency becomes an institutionalized "practice" and not merely a "refresher" course. Partner with Oklahoma colleges and universities and the Department of Education to develop outreach programs to encourage participation of minority high school and college students in research (especially from a multidisciplinary perspective). Develop new ways to inform minority students about training opportunities in health disparities research, including informational reports, Websites (i.e., MEDLINEplus), tracking systems to assess the effects of programs, and conferences with faculty from Hispanic-Serving institutions, Historically Black Colleges and Universities (HBCUs), Tribal colleges and universities, and other academic centers, including participation in annual meetings of minority professional and medical associations. A possible long-term benefit would be to encourage the OSDH and ODMHSAS to hire these trained professionals as both interns and full-time employees consistent with agency hiring polices.

4. Assist in the development of an ongoing preventive health education and awareness campaign involving the OSDH, ODMHSAS, the Governor, legislative officials and other partners to address health disparities issues through the assurance of health care access. This may include activities such as, radio and

television spots, newspapers, and community forums. Churches and schools may also participate in this awareness campaign.

Rationale: This can bring awareness on an ongoing basis to the public of the serious healthcare access issues that are present in the state. A new perspective will be to focus on health disparities to complement current health care initiatives promoted by state policymakers and health leaders. This will also provide an opportunity for state leaders to address continuing reports of the poor health status of Oklahoma's population, driven largely by the poor health condition of racial and ethnic populations. Examples of these types of leadership efforts include the president of Oklahoma University spearheading the development of a diabetes prevention center;[19] and (2) the governor of Pennsylvania getting involved in a public campaign to shed light on the severity of health disparities in that state.[20]

The development of a consistent preventive health campaign on a statewide basis can help in prioritizing health concerns among children and families; fostering improved relationships between health care providers and patients with different cultural backgrounds; enhancing health literacy and awareness for racial and ethnic populations; and generally, creating a healthier workforce that will lead to improved opportunities for economic development for the state.

Strategy: Provide support to a consistent ongoing public awareness campaign developed to focus on preventive health education and health awareness information. The campaign would utilize all media driven opportunities (i.e., television, radio, newspaper (local/statewide), churches, and health agency functions that focus on positive outcomes management). The program would target health promotion activities using state leaders, key members of influence throughout the state (i.e., the Governor and/or high ranking legislators/ private citizens, etc.) This initiative would be directed to inform, communicate, and initiate public awareness and activities that will promote healthy outcomes, prevention strategies and ongoing health management updates. The intended

outcome would be to increase total health awareness and promote healthy behaviors, attitudes, activities, and quality of life of Oklahoma populations both socially and economically. The OSDH and ODMHSAS communication departments would serve as the point of contact in this collaborative effort.

5. Encourage the OSDH and ODMHSAS to develop collaborative partnerships with local communities and federal state and local agencies to work on key cultural barriers that may impact health access and health education.

   Rationale: The issue of accessibility of health care for the underserved envelops a mirage of possible socio-cultural as well as economic etiologies. Definitions and emerging solutions should not only be on a holistic scale across the state but also community- specific. Many community (local), state and federal agencies have developed coalitions, taskforce groups, agencies, and federally funded programs to address specific health issues. Most are working independently and have limited knowledge of what possible partners can be connected under the same mission and goals. By having local, state, and federal partners working more collaboratively together monetary and goal-oriented achievements can be developed, implemented, and evaluated for effectiveness to reach the target audience. This would also decrease the amount of duplication of services. Many counties also may need assistance in building needed councils to address health issues to be presented to influence future creations of policy or amendments to current policy.

   Strategy: Develop a database whereby local, state and federal programs/groups that are working on similar issues can be grouped. This database can be used for identifying various potential collaborative partners for coalition building and community-based program development. This can be linked on various programs within the OSDH and ODMHSAS to demonstrate that collaboration is taking place on various levels to ensure optimal health care. This could include a structured reporting system among the relevant health and mental health program

areas within the OSDH and ODMHSAS. In addition, a possible mechanism would be to have meetings (i.e., quarterly, semi-annually) between the entities with impact on health access: i.e., OSDH, ODMHSAS, Oklahoma Health Care Authority, Oklahoma Primary Care Association, the Department of Human Services, Turning Point, hospitals, clinics, medical schools, faith-based organizations, etc.) to discuss common health care access issues, concerns and program areas.

Finally, the Oklahoma State Board of Health has endorsed Turning Point as the vehicle the OSDH will use to improve health in Oklahoma. The Oklahoma Turning Point initiative is transforming public health in the state by establishing successful health education/ health promotion programs through community partnerships. Funded in part by a grant from the Robert Wood Johnson and W.K. Kellogg foundations, Turning Point was launched in January 1998 with three pilot community partnerships in Cherokee, Texas, and Tulsa counties. Each of these "model" partnerships achieved significant success in assessing local needs, establishing local priorities and implementing strategies tailored to the unique needs of the community at large. The key objective for Oklahoma Turning Point is to develop and expand similar community health improvement partnerships into each of the state's 77 counties. Currently, there are 50 community partnerships located throughout the four quadrants of the state – Regional Turning Point Field Consultants provide technical assistance to assist the partnerships in identifying local health priorities, implementing strategic health improvement plans, and evaluating program impact. In addition, the Oklahoma State University Cooperative Extension Service (located in each county of the state) can help facilitate the community development aspect by creating tools that assist local groups with community leadership training. Using a community participatory base for developing solutions, state and federal agencies can connect with these community partners to address key health issues. This will create and foster buy-in from the community that will generate successful outcomes.

Suggested Readings

Agency for Healthcare Research and Quality (AHRQ). (2003). *National Healthcare Disparities Repor*t. Rockville, MD: U.S. Dept. of Health and Human Services.

Betancourt, J.R., Green, A.R., Carrillo, J. E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches.* Commonwealth Fund pub. No. 576. New York: Commonwealth Fund. www.cmwf.org

BPHC. (2001). *Cultural competence works*. Bethesda, MD: HRSA. www.bphc.hrsa.gov

Carter-Pokras, O., & Baquet, C. (2002). What is a "Health Disparity"? *Public Health Reports, 117*, 426-433.

Cross, T, Bazron, B, Dennis, K., & Isaacs, M. (1989). *Toward a culturally competent system of care, Vol. 1.* Washington DC: Georgetown University.

Drexler, Madeline (2005). *Health Disparities & the Body Politic*. Harvard School of Public Health Symposium 2005. Boston, MA: Harvard School of Public Health.

HRSA (2001). Cultural competence works. Rockville, MD: HRSA Center for Managed Care. www.hrsa.gov/financemc/

HRSA Care Action. (2002, August). Mitigating health disparities through cultural competence. *HRSACare Action.* http://hab.hrsa.gov

HRSA. (2000) *Eliminating health disparities in the United States.* Rockville, MD: HRSA

Kitchen, A. (1999) Treating immigrant populations-Cultural competence in health care. *Bioethics Forum, 15*(2), 11-17.

Majumdar, B., Browne, G., Roberts, J., Carpio, B. (2004). Effects of cultural sensitivity training on health care provider attitudes and patient outcomes. *Journal of Nursing Scholarship 26*(2), 161-166.

McDonough, J.E., Gibbs, B.K., Scott-Harris, J. L., Kronebusch, K, Navarro, A.M., & Taylor, K. (2004). *A state policy agenda to eliminate racial and ethnic health disparities.* Commonwealth Fund pub. No. 746. New York, Commonwealth Fund. www.cmwf.org

Saldana, D. (2001) *Cultural competency: A practical guide for mental health service providers.* Austin TX: Hogg Foundation. www.hogg.utexas.edu

Trevalon, M. (2003). Components of culture in health for medical students' education. *Academic Medicine, 78*(6), 570-576.

Youdelman, M., & Perkins, J. (2005). Providing language services in small health care provider settings: Examples from the field. Commonwealth Fund pub. No. 810. New York: Commonwealth Fund. www.cmwf.org

References

[1] The Haves and the Have-Nots: Health Disparities. 2002 State of the State's Health Interim Report. Oklahoma State Board of Health. July 2002.

[2] Webster's International 2nd

[3] HRSA, 2001

[4] Health Disparities & the Body Politic. Harvard School of Public Health Symposium Series 2005.

[5] National Health Disparities Report, 2004.

[6] U.S. Department of Health and Human Services. "Healthy People 2010". www.healthypeople.gov.

[7] OSDH Board of Health, 2002 State of the State's Health Interim Report, "The Haves & Have-Nots".

[8] OSDH, Office of the Commissioner.

[9] Kaiser Daily Health Report, March 31, 2005. www.kaisernetwork.org.

[10] Kaiser, Ibid., June 14, 2005.

[11] Kaiser, Ibid., September 6, 2005.

[12] U.S. Centers for Disease Control and Prevention, Office of Minority Health. Issue Brief: "Eliminating Racial and Ethnic Disparities. Date unknown. www.cdc.gov/omh

[13] Robert Woods Foundation, "American Views of Disparities in Health Care", December 9, 2005.

[14] Ibid.

[15] U.S. Centers for Disease Control and Prevention, *MMRW Weekly*, August 27, 2004.

[16] Kaiser Foundation Health Report, Oklahoma, 2005.

[17] Ibid.

[18] Janet Pearson, " OSU Medical School Plight Part of a Bigger Health Crisis," Editorial. Tulsa World, May 7, 2006.

[19] Daily Oklahoman, December 9, 2005.

[20] Kaiser Daily Health Report, April 21, 2006.