Governor's Task Force on the Elimination of Health Disparities

Final Report ● January 2010

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Executive Summary

In 2003, the Oklahoma Senate through Senate Bill 680 created the Oklahoma Task force to Eliminate Health Disparities. 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. The Oklahoma Task Force to Eliminate Health Disparities formed three subcommittees to tackle the complex multi-cultural and economic issues associated with health disparities: 1) Cultural Competency; 2) Enhanced Data Capacity (Integrated Data); and 3) Health Access.

In July 2006, the Oklahoma Task Force to Eliminate Health Disparities published its report on the finding and recommendations for implementing targeted programs to move Oklahoma closer to a state of health through the reduction and eventual elimination of health disparities. On February 23, 2007, Governor Brad Henry through Executive Order 2007-8 established the Governor's Elimination of Health Disparities Task Force to continue the work of the Oklahoma Task Force to Eliminate Health Disparities. The purpose shall be to help the Oklahoma Department of Health eliminate health access disparities in Oklahoma among multicultural, disadvantaged and regional populations. The task force shall focus on at least six (6) major areas of health including, but not limited to, cardiovascular disease, infant mortality, diabetes, cancer and adult and child immunizations.

A traditional view of health has usually focused on measureable increases or decreases in chronic and infectious disease burdens or levels of childhood vaccination and of late access to necessary primary and specialty medical services. Recent studies have found a growing connection between the health of individuals and the "health" of their community. Specifically research has confirmed infrastructure plays a significant role in affecting the decisions individuals make or cannot make and its affect on levels of chronic and infectious disease. Additionally clear linkages are forming between health outcomes and developmental opportunities at the individual and neighborhood level. This interaction has played a significant role in the national health ranking of Oklahoma. Understanding this interaction is fundamental to addressing health disparities in Oklahoma.

Three subcommittees were tasked with developing recommendations focused on the interaction between direct and indirect influences on health and health care issues while building upon the work of the previous Task Force: 1) Informed Public; 2) Healthcare Availability/Access and Equity; 3) Integrated Data. Significant recommendations of the subcommittees are summarized below:

Informed Public

- Establishing health education in Oklahoma public schools (grades K – 12) with Priority Academic Student Skills guidelines utilizing local school districts to determine health education curriculum that would include but not be limited to physical activity, nutrition, violence prevention, alcohol, tobacco and other drugs, behavioral health, oral wellness, environmental health growth and development, injury prevention and wellness.
- Encourage at risk populations, children and young adults to live healthy lifestyles by providing incentives to promote healthy behavior.
- Increase efforts to promote Call 2-1-1 and Internet-Based Joint Oklahoma Information Network (JOIN) Services to expand the public's awareness of their services.

Healthcare Availability/Access and Equity

The gap between the best possible care and actual care is widening. Reversing the trends in health disparities and those related to access and availability of timely, affordable, culturally relevant/competent and consistent evidenced based health care will require State mandated action in areas which:

- Expand workforce development initiatives;
- Improve evidenced based decision making in the creation of comprehensive strategies that encourage collaboration and linkages with existing community assets for a responsive and efficient health care delivery system;
- Promote and encourage the enhancement of system capacity through innovative strategies such as telemedicine and telehealth;
- Increase funding for education programs and providers; and
- Remove barriers that interfere with access to quality health care

Integrated Data

The elimination of health disparities in Oklahoma will not occur through any single action, but only thought multiple significant events. Developing a clear foundation from which decisions are made grounded in quality data is one such advancement necessary for eliminating health disparities and signals the type of event that will result in long-term health improvement. It is strongly recommended that the Governor adopt the following recommendations and establish an Executive Order directing Oklahoma State Agencies to comply.

- Through executive order, the Governor of Oklahoma establishes the Oklahoma Data Dictionary Clearinghouse. The Oklahoma Data Dictionary Clearinghouse will be a web-based searchable statewide data dictionary initially hosted by the United Way of Central Oklahoma (or similar independent, non-governmental organization). The United Way

would serve as a neutral location for initiating the Clearinghouse addressing concerns that a single state agency would hold more knowledge than others and would serve as a reminder for the need to have communities included in the decision making process.

- The Governor of Oklahoma establishes the Oklahoma Data Dictionary Clearinghouse Oversight Committee that would develop rules for accessing, using, aggregating, and reporting data variable collection under groupings contributing directly and indirectly to the calculation of current health indices. Members on the oversight committee should represent all contributing state agencies, Oklahoma City-county Health Department, Tulsa County Health Department, representatives from the Governor's Task Force for the Elimination of Health Disparities, and representatives of clients/consumers served by each contributing agency.
- The Governor of Oklahoma directs state agencies to develop listings of all data variables collected by internal programs or projects and provide that state agency data variable list to the United Way of Central Oklahoma.
- The Governor of Oklahoma directs the establishment of resources for long-term sustainment of the Oklahoma Data Dictionary Clearinghouse.
- The Governor of Oklahoma requires all state agencies to participate in the Oklahoma Data Dictionary Clearinghouse.

Informed Public Committee
Executive Summary

KNOWLEDGE! EMPOWERMENT! BETTER HEALTH!

Inequities in health status are increasing in Oklahoma. According to the National Association of County and City Health Officials, research documents show that poverty, income and wealth inequality, poor quality of life, racism, sex discrimination, and low socioeconomic status are the major risk factors for ill health and health inequities.

In addressing health inequities, the Informed Public Committee for the Task Force to Eliminate Health Disparities provides a summary of our recommendations. Health experts shared with us research and current trends that prevent citizens from being informed of health related programs. Understanding the complexity of health disparities from various perspectives have led to the following recommendations.

Recommendations

1. Establish health education in Oklahoma public schools (grades K-12) in accordance with Priority Academic Student Skills guidelines utilizing local school districts to determine health education curriculum that would include but not be limited to physical activity, nutrition, violence prevention, alcohol, tobacco and other drugs, behavioral health, oral health, environmental health, growth and development, injury prevention and wellness.

2. Encourage Oklahoma's Medicaid families to live healthy lifestyles by providing beneficiaries (ages 4-20) incentives to promote healthy behavior.

3. Increase efforts to promote Call Number 2-1-1 and Internet-Based Joint Oklahoma Information Network (JOIN) Services to expand the public's awareness of their services

Regarding recommendation number one, the United Health Foundation ranks Oklahoma as one of the unhealthiest states in the nation ranking at #49 in 2009. Healthy and fit students learn better and establishing healthy habits early in life will carry over in their adult years. It is important for students to have the knowledge and skills to make healthy choices early in life.

Regarding recommendation number two, the Oklahoma Medicaid population has a large percent of minorities per capita than Oklahoma's other private payer insurance plans. One of the largest state expenditures for the Oklahoma Health Care Authority and the Oklahoma taxpayer are the medical services required to treat various diseases and conditions contributing to the obesity of minorities. There are state models across the nation to pattern an Oklahoma program that encourages lifestyle changes through an incentive plan.

Regarding recommendation number three, JOIN and Call 2-1-1 will become an ever-increasing public resource for important information on health care and social services, both public and private, as Oklahoma minority populations' increase. An awareness campaign will be needed to inform the general public about the types of health services available within Oklahoma communities.

This committee met monthly to develop these recommendations and believes the proper combination of early health education, individual empowerment, coupled with increased awareness of current health services will indeed improve the health outcomes of Oklahoma's diverse populations. Oklahomans should be informed of the available health services and resources to facilitate easy access to health care and healthy living while being encouraged to take an active empowered role in their lives.

In conclusion, the Informed Public Committee believes the following:

- We believe the quality of one's health services shall not be affected by their racial, ethnic, or social demographic status.
- We believe that all persons shall have access to health services regardless of their gender, racial, or ethnic status.
- We believe every Oklahoman should be guaranteed access to affordable, basic health services.
- We believe individuals must have free access to information necessary to maintain optimum personal and community health.
- We believe individuals and the community should be empowered to take an active role in their health
- We believe to maximize the health of all individuals; every individual and all systems that impact health must work together and be held accountable.

Recommendation – REQUIRE HEALTH EDUCATION

Establishing health education in Oklahoma public schools (grades K-12) in accordance with Priority Academic Student Skills guidelines utilizing local school districts to determine health education curriculum that would include but not be limited to physical activity, nutrition, violence prevention, alcohol, tobacco and other drugs, behavioral health, oral health, environmental health, growth and development, injury prevention and wellness.

Background

Business leaders know that when Oklahoma ranks so poorly in key health issues, it hurts their efforts to recruit and retain talent. Those engaged in efforts to address major health issues understand that healthy workers are more productive and absent less often, and help employers control rising health insurance costs. With 50 cents of each health care dollar being used to treat preventable diseases, there is a strong need for greater personal responsibility and better lifestyle choices.

In order to make good choices, however, Oklahoma residents need to know what the choices are, and to be well informed about the consequences of their choices. Unfortunately, Oklahoma is one of only two states in the nation that has no requirement in our public schools for health education even though the American Academy of Pediatrics and the Centers for Disease Control and Prevention recommend comprehensive health education in grades kindergarten through 12.

Researchers at the University of Oklahoma Health Sciences Center and Oklahoma State University Nutrition Services recently completed a comparative study of eight Oklahoma elementary schools with similar demographics regarding ethnicity, free/reduced lunch and student/teacher ratios. The four model schools were participating in a Coordinated School Health Program, including fitness testing, physical education and nutrition education. At the end of the study, not only were the students healthier and fitter, but also in each case, the API scores in the pilot schools rose dramatically – in one case over 260%. Healthy and fit students learn better, and are creating healthy habits that will carry over into their work lives.

In 2005, the Oklahoma legislature reinstated physical education in grades K-5. In 2008, this was expanded to include health and nutrition education, along with additional P.E. Yet there is no requirement of this nature in the upper grades. About half of the 539 schools districts offer some type of physical education or health and nutrition classes in grades 6-8 that are attended by roughly 58,000 of the 135,000 students.

In this global economy, when students need to be at the top of their game, Oklahoma should ensure they have the knowledge and skills to make informed choices that will establish life-long health habits. Healthy bodies support strong minds!

Technical assistance for this recommendation was acquired from the Oklahoma Institute for Child Advocacy. This Task Force includes two additional items as support documents, 1) 2009 Children's Agenda – REQUIRE HEALTH EDUCATION Policy Brief and 2) Health Education Profile – Carter County.

REQUIRE HEALTH EDUCATION

Policy Brief

Oklahoma is one of the unhealthiest states in the nation. The United Health Foundation ranks the state 47th in the overall health of its residents in 2007, slipping from 44th in 2006. Oklahoma ranks at the very bottom of all health risk factors:

• Income	47	• Tobacco Use	47
• Exercise	47	• Nutrition	50
• Health Insurance	44	• Mental Illness	50
• H.S. Education	41	• Diabetes	46
• College Education	47	• Heart disease	50

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In order to make good choices, however, Oklahoma residents need to know what the choices are, and to be well informed about the consequences of their choices. Unfortunately, ***Oklahoma is one of only two states in the nation that has no requirement in our public schools for health education***, even though the American Academy of Pediatrics and the Centers for Disease Control and Prevention recommend comprehensive health education in grades kindergarten through 12.

Oklahoma Research: Healthy students are smarter students!
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RECOMMENDATION:

The 2009 Children's Agenda supports establishing a health education requirement in grades 6-8 in Oklahoma public schools, in accordance with the PASS (Priority Academic Student Skills) guidelines. The topics of instruction will be determined by each local school district, and should include, but not be limited to:

- Physical activity
- Nutrition
- Alcohol, tobacco and other drugs
- Behavioral health
- Oral health
- Environmental health
- Growth and development
- Injury prevention
- Wellness

The PASS Guidelines state that a "well-informed, self-directed student has the foundation for leading a healthy, productive life. By recognizing that many health problems and causes can be prevented, children can reduce many of the risks generally encountered during adolescence and adulthood."

rose dramatically – in one case over 260%. Healthy and fit students learn better and are creating healthy habits that will carry over into their work lives.

Results of Changes in School Policies

Schools by themselves cannot – and should not – be expected to address the nation's most serious health and social problems. But changing school policies can make a significant difference in establishing positive health habits that will lay the foundation for future good health. In 2005, the Oklahoma legislature reinstated physical education in grades K-5, when only about one-third of our students were physically active for the recommended 60 minutes a day for five or more days per week. By 2007, that number had risen to almost 50%, a 30% increase in just two years!

Status of Health Education in Oklahoma

In 2008, the P.E. requirement in grades K-5 was expanded to include health and nutrition education, along with additional P.E. Yet there is no requirement of this nature in the upper grades. About half of the 539 schools districts offer some type of physical education or health and nutrition classes in grades 6-8 that are attended by roughly 58,000 of the 135,000 students.

Many classes are being taught by certified teachers in the classroom. In some districts, schools call upon one of the 28 health educators employed by county health departments throughout the state to provide health education. In addition, many community groups, including local hospitals, offer their nutritionists, social workers, nurses, county extension workers and other professionals, to provide health education to students.

Carter

Anna Duran

Form B: Priority Areas 4) Healthy Children & Families, 5) Immunization & Infectious Disease, 6) Injury & Violence Prevention, 7) Terrorism & Emergency Preparedness, 8) Development & Regulations of Health Related Systems, 9) Public Health Systems Development, & 10) Access to Care

Focus Area (#)	Program/ Activity Description	Outputs	Outcomes
(4) Healthy Children & Families	A. Possibilities-After school Hispanic club for teens focusing on dropout prevention and teen pregnancy. B. Health class- I give presentations during health classes once a week for 32 weeks at Ardmore Middle School. Topics include CPR, bullying, healthy relationships and nutrition. C. Camp-sit-a-lot: Baby sitting class for teens	A. Program serves 15 teens after school one day a week for 32 weeks in Ardmore. B. Program serves 80 children C. 60 students have been through 12-hr training during past year.	A. Scores on pre & post-tests (knowledge of reproductive prevention & healthy relationships) improved from 60% to 90% by end. Standardized test scores improved. B. Post-tests evaluations are given at end of each topic and grades are taken. Scores vary. C. Evaluation methods at end of training include CPR certification test, computer baby score printout and participant written course evaluation. All participants became CPR certified
(5) Immunization & Infectious Disease	HIV/STD, immunizations, blood borne pathogens presentations in schools	Approximately 250 staff members attend staff trainings yearly. Approximately 40 students receive HIV/STD training yearly in Carter.	Staff members take OSHA blood-born pathogens test yearly. Students voice understanding of transmission and protection of HIV.
(6) Injury & Violence Prevention	Safe Kids Program – Our local Safe Kids program focuses mainly but not entirely on car seats. Parents view video & receive pamphlets.	Car seats are provided and installed at CCHD by request and at monthly community car seat checks.	An average of 45 car seats are provided monthly. We rely on state injury data for success evaluation.

<u>One County Success Story or "Day in the Life":</u> The highest teen pregnancy rate of all ethnic groups is among Latino youth. In fact, three out of five Hispanic girls have been pregnant by age nineteen. The highest school drop out rate of all ethnic groups is also among Latino youth.[2] *Posibilidades* is a program aimed at empowering Latino youth through self esteem development, positive role models and purposeful activities showing the end result of lowering the teen pregnancy rate and school drop out rate. *Posibilidades* is a positive after school model usually conducted in Spanish for teens 12-15 years old. It involves activities inside and outside the classroom. Topics inside the classroom include Healthy relationships (sexual health), tobacco, alcohol and other drugs, social skills, cultural identity, social skills, goals, tutoring, self-expression through arts. Outside the classroom: Community participation, Parent meetings & newsletters, Good Shepherd clinic agreement for uninsured health care, free counseling at CCHD.

Recommendation –INCENTIVES FOR MEDICAID FAMILIES

Encourage Oklahoma's Medicaid families to live healthy lifestyles by providing beneficiaries (ages 4-20) incentives to promote healthy behavior.

Background

The United Health Foundation released their annual report that ranks the health of each of the United States. Oklahoma moved up from 47th to 43rd, which ranks Oklahoma in the bottom 10. This proposal could possibly impact one of the indicators of this report, which is obesity. In a July 2007 brief, the Center for Health Care Strategies noted "state Medicaid agencies have not traditionally sought to influence recipients' health-related behaviors. Wellness programs, like smoking cessation, are still not universally covered by Medicaid agencies and encouraging healthy behaviors represents a new direction for Medicaid agencies toward promoting health and wellness. Improving consumer's health and wellness-related behaviors is important for the long-term health of recipients. Unhealthy behaviors have become the top causes of mortality and morbidity in the United States."

It should also be noted that researchers estimate that 15% of all children in the U.S. are overweight, and nearly 25% of African American and Hispanic children are overweight. The proportion of adolescents from poor households who are overweight or obese is twice that of adolescents from middle and high-income households. The Oklahoma Medicaid population has a larger percent of minorities than Oklahoma's other private payer insurance plans, making minority obesity one of the largest state expenditures for the Oklahoma Health Care Authority. Being obese increases a child's risk for serious childhood medical problems to include pre-diabetes, heart disease, high blood pressure, high cholesterol levels, sleep apnea, and psychological problems like poor self-esteem and depression. In addition to the risk to children during childhood, research over the last 40 years demonstrates that overweight kids are at greater risk of becoming obese adults, with all the health problems associated with obesity lasting through the lifespan. It is the intent of this recommendation to incentive healthy lifestyles at an early age that can break the cycle of chronic obesity and transform the lives of Oklahoma's poorest and unhealthiest populations.

Models

The Oklahoma Health Care Authority (OHCA) has reviewed this recommendation and the following are suggested as potential models to pattern an Oklahoma program.

America's Health Insurance Plan organization reports "health plans recognize the complex problem of obesity requires collaboration with community organizations that can have an impact outside the physician's office. Incentivizing members for adhering to a weight management program or making healthy lifestyle changes is a popular strategy

for many health plans. Lifestyle change works best if the entire family is involved, and encouraging change at home is as important as making changes in the school environment." The report lists the activities for many of the major insurance carriers. Following the lead of private insurance plans, several states have initiated programs to encourage Medicaid beneficiaries to practice healthy behaviors. Flexibility under the Deficit Reduction Act (DRA) has enabled some of the states to target and tailor programs for select populations utilizing various incentives aimed at the development of healthy behaviors. A description of healthy behavior initiatives in other states is listed below:

Florida

One of the most high-profile state programs promoting healthy behaviors is the Enhanced Benefits Account pilot project, which is part of Florida's Medicaid Reform. This program is designed to reward Medicaid recipients who engage in activities that can improve their health such as showing up for doctor's appointments, undergoing routine screenings, losing weight or quitting smoking. Participation in such activities will earn credits that recipients can use to buy health-related items at a pharmacy. All individuals enrolled in Florida Medicaid Reform are eligible to earn and use credits in the Enhanced Benefits Account program. Enrollees earn credits by taking part in a healthy behavior. Each type of healthy behavior and the corresponding credit amount are defined and approved by the state. Individuals may earn up to $125 in credits during the first year of the pilot program (September 1, 2006-June 30, 2007), but Florida has not announced the earning limit for subsequent years. Healthy Benefits Accounts became available November 1, 2006. Enhanced Benefits Accounts are to be funded through savings incurred by the Medicaid program under the state's new •1115 waiver, although there is no special fund designated for this purpose.

West Virginia

Rewards for healthy behaviors, such as those proposed in Florida, are being offered or
considered by several states championing Medicaid reform. In one new approach, West Virginia requires Medicaid recipients in three counties to sign a Medicaid Member agreement, called a "personal responsibility contract," that outlines recipient rights and responsibilities. Enrollees are enrolled in managed care plans either upon gaining eligibility or upon renewal. The members are then automatically enrolled in a basic health plan, which is based on the current Medicaid benefit package. By signing the personal responsibility contract, recipients agree to accept responsibility for promoting personal health and to avoid "using drugs illegally, drinking too much alcohol, and being overweight." They also agree not to use an emergency room for non-emergent care. If the member signs the agreement and follow its tenets, they earn extra benefits, including access to tobacco cessation and nutritional education programs; diabetes care; chemical dependency/mental health care; adult cardiac rehabilitation; chiropractic services; emergency dental services; skilled nursing care; and orthotics/prosthetics for children. Enrollees who do not wish to join the enhanced plan or who decide disenrollment will receive the standard Medicaid benefit

package. Failure to honor the agreement could also result in exclusion from the special benefit and incentive programs.

Kentucky

Similar to West Virginia, Kentucky intends on offering additional benefits, such as dental and vision care, to recipients who adhere to disease management programs. Kentucky was the first state to receive federal approval under the DRA to make significant changes to its Medicaid program through a state plan amendment. Under a program called KyHealth Choices, Medicaid benefits will be tailored to different recipient categories. Global Choices is the standard benefit package offered to all enrollees. Comprehensive Choices provides additional benefits for members who need long-term care and covers nursing facility level of care. The Optimum Choices benefit covers (1) disabled adults in need of ICF/MR level of care, (2) those who are at risk of institutionalization, and/or (3) those currently served in the Supports for Community Living waiver. The fourth option, Family Choices, is designed for children and will serve those currently covered by the KCHIP program and some children served under the traditional Medicaid Program.

KyHealth Choices will also encourage Medicaid members to be personally responsible for their own health care. Kentucky is developing a web-based resource directory of public and private, traditional and non-traditional long-term care services for enrollees with nursing home level of care needs. They are also implementing disease management programs and a series of educational programs as part of the KyHealth Choices' Get Healthy Benefits, which allows individuals with targeted diseases to access additional benefits if they participate in healthy practices.

Idaho

In Idaho, Medicaid recipients who engage in healthy behaviors can accrue money to a medical savings account that can be used to pay program premiums or to purchase additional health promotion services, such as a smoking cessation program. Idaho's reform plan allows Medicaid beneficiaries to select one of three benefit plans: a basic plan designed for healthy children and adults; an enhanced plan for those with more complex health care needs; and a coordinated plan for dual eligible populations (dual eligible populations are those that qualify for both Medicaid and Medicare.) Enrollees can opt out of these packages at any time and return to standard Medicaid. All three packages will include new benefits, including preventive and nutrition services to help obese individuals, smokers, and others adopt healthier habits. The working disabled will also be able to purchase Idaho's basic Medicaid benefits package – an approach similar to recent Medicaid reforms in Maryland. Detailed descriptions of the Florida, Idaho, Kentucky, and West Virginia reforms can be found on the following web-link :

http://www.emdhealthchoice.com/pdf/healthybehaviorsJCRfinal12-06.pdf

The two programs that could be modified to fit with the recommendation of encouraging Oklahoma's SoonerCare members to live healthy lifestyles would be that of Florida or Idaho. The recommendation, "encouraging Medicaid families to live healthy lifestyles by providing beneficiaries (ages 4-20) incentives to promote healthy behavior," and focusing on obesity, could be adapted from either the Florida or Idaho model. Participants would receive monetary incentives for participating in designated healthy activities in the form of credits that can be used to purchase products and services that are 'healthy'.

Implementation

To implement a similar program, after determining its scope, i.e. what behaviors to reward, the amount of credits, and program stipulations, one method of operating the program could be through contracting with a third party plan administrator to develop, promote and pay incentives to the members who receive the credits. The concept of incentives to promote healthy behavior is not new to health plans; Oklahoma's Employee Benefits Council offers incentives for health behaviors through OK Health. One agency's offer of this benefit, is worded as follows:

> As your benefits office, the Employees Benefits Council has coordinated several incentives for OK Health participants.
> *** Financial Incentives - $100.00, $300.00, $500.00**
> Three levels of financial incentives are offered by participating agencies (check with your agency for details).
> *** No co-pay or deductible**
> Initial PCP visit and specified lab work will be waived - you must stay within Network. Out of network does not apply.
> *** Discounts**
> On selected Fitness Centers throughout Oklahoma
>
> Currently, the [state agency] is offering the $300.00 incentive which comes in three installments: $75.00 for completing the enrollment process, $100.00 for twelve (12) follow ups and $125.00 for twelve (12) monthly evaluations.

Papers from the Center for Health Care Strategies (web-links below) give more insight into the programs of Florida and Idaho as well as program details located on each state's Medicaid website.

http://www.chcs.org/usr_doc/Medicaid_Efforts_to_Incentivize_Healthy_Behaviors.pdf
http://www.chcs.org/usr_doc/Encouraging_Healthy_Behaviors_in_Medicaid.pdf
http://ahca.myflorida.com/Medicaid/Enhanced_Benefits/
http://www.heathandwelfare.idaho.gov/site/3629/default.aspx

Recommendation – PROMOTE 2-1-1 AND JOIN SERVICES

Increase Efforts to Promote Call Number 2-1-1 and Internet-Based Joint Oklahoma Internet Network (JOIN) services to expand the public's awareness of their services.

- **2-1-1** is an easy to remember telephone number that connects people to important community services and volunteer opportunities. While services offered vary from community to community, 2-1-1 provides callers with information about and referrals to human services to meet every day needs and in times of crisis, www.211oklahoma.org
- **JOIN** is a partnership of numerous Oklahoma agencies with a shared vision to provide improved, personalized access to programs and services, www.join.gov

Background

There are seven 2-1-1 call centers operating in the State of Oklahoma. The call centers are a public-private partnership, funded by individual donations, the United Ways of Oklahoma, as well as various levels of government with a large portion of operating expenses funded by the State of Oklahoma through the Department of Human Services.

By calling 2-1-1, individuals are able to obtain contact information, hours of operation and qualification requirements for health and human services ranging from food assistance, utility assistance, to mental and medical health assistance. While 2-1-1 is not a direct service provider, they are the only entity where you can call one number and receive referrals in many disciplines by church organizations, non-profit organizations, as well as governmental organizations.

Problem

It has been reported that the economic downturn facing our country is expected to get worse. The number of individuals that will be seeking financial and other assistance can be expected to increase, with more citizens being unable to meet their most basic needs. 2-1-1's throughout the State have most if not all of the resources in their databases of organizations that provide assistance that are either free or based upon the individual's ability to pay. While there is not enough organizations or funding to help everyone, the needs will be increasing without any foreseeable increase in funding for these organizations.

Problem

Our minority populations living in Oklahoma are increasing in size. 2-1-1 and JOIN need to increase their multi-lingual capacity in both verbal and written form. Enhancing this capacity will increase awareness that 2-1-1 and JOIN are information clearinghouses. It will further assure that the general public will understand the types of services available within our communities statewide.

Currently, thousands of Oklahoman's are helped each year through the efforts of our faith-based community, the non-profit organizations and governmental agencies. By directing additional resources to promote the 2-1-1 and JOIN to promote availability of community services but also to those organizations that assist those most in need, the quality of life simply by meeting their basic needs could be dramatically improved.

Implementation

Here are some comments received when asked how we might fund the services needed by those most challenged:

- Possible redirection of State funds from an existing program where results indicate questionable success, or could be a new stream of funds based upon some other source, such as a surcharge to utilities, property tax or however the state would choose to fund it.
- Maybe start with a pilot program for a year, perhaps in one part of the state, which would allow opportunities to improve the process and eliminate any gaps in service or control. For a pilot program, funds could be redirected from a state agency that would be responsible for monitoring the effectiveness of the program.
- There are a lot of folks that have taken advantage of governmental programs, and these programs are many times not sufficiently staffed to provide adequate oversight. By backing into this slowly, working with the non-profit organizations that are used to having very limited funding. One of the biggest hurdles would be in developing a process where individuals would not be able to go from agency to agency. During recent hurricane relief and ice storm shelter operations, the non-profits all worked together to ensure that there was no duplication of services, so it can be done.

Health Care Availability and Equity Sub-Committee
Executive Summary

Health care access is generally acknowledged as a crucial link to improved health outcomes for all populations. The Health Care Availability/Access and Equity (Subcommittee) recognizes that Oklahomans are in great need of access to quality health care to improve their health status. Thus, the Subcommittee is charged with developing recommendations for improving capacity and access to Health care services and providers in an effort to: (1) eliminate disparities in health status among diverse racial and ethnic populations; and (2) address barriers to ethnic minorities obtaining and maintaining their optimal health potential.

Health and socioeconomic trends in the State of Oklahoma suggest the need for significant improvement in well-being specifically in the areas of poverty and literacy; and in the top 6 health concerns responsible for the greatest area of disparity among Oklahomans and specifically ethnic minorities. According to the 2008 United Health Foundation, America's Health Ranking Report, there were improvements in the State's overall health rankings from 47th in 2007 to 43rd in 2008. However, compared to other states, Oklahoma continues to have a high incidence of preventable diseases to include:

- Heart Disease (49th)
- Stroke (47th)
- Diabetes (44th)
- Overweight and Obesity (43rd)
- HIV/AIDS and other STDs (no ranking)
- Prevalence of Smoking (48th) and Lung Cancer (40th)

Not only are these preventable diseases significantly impacting racial minorities, the United Health Foundation also reports that Blacks are disproportionately impacted by low birth weight babies. Additionally, minorities, specifically Hispanics are most likely to have no insurance compared to whites (56.8%vs 20.8%).

The gap between the best possible care and actual care is widening and continues to exist between the majority population and especially for ethnic and racial populations. For example, a 2004 data report on Health Disparities and minorities published by the Data Subcommittee of the 2003-2006 Legislative Task Forces to Eliminate Health Disparities made the following observations regarding the health status of minorities:

- They are less likely to receive health screenings, equitable treatment and affordable health insurance or services;
- They continue to have the poorest health outcomes and social-economic status;
- They are more likely to be poor, less educated and burdened with diabetes, cancer, heart disease and substance abuse when compared to the larger population;
- They lag behind in education and income which are strong indicators of whether or not a person has access to health care services. The higher the

education and income, the more likely individuals are to have better health opportunities and outcomes.

More recently, in a 2009 report published by the Kaiser Foundation it states Oklahoma Minorities are lagging in health status (diabetes, infant mortality, AIDS) and socio-economic status (poverty, Medicaid enrollment, and uninsured) which are primary determinants of health status. (Kaiser Foundation, 2009 update) Specifically, Oklahoman's 2007 poverty rates show that Hispanics (29%), Blacks (27.4%) and Native Americans (23.6%) far exceed the rates for Whites (13.3%) and Asians (9.2%). (Oklahoma Policy Institute, 2008)

In an effort to reverse the trends in health disparities for citizens of Oklahoma, the Subcommittee supports the position that evidenced based health care must be accessible, available, timely, affordable, culturally relevant, linguistically appropriate, and coordinated for all Oklahomans. Therefore, the Subcommittee establishes as its' goals – to increase access to health care and to raise awareness on health disparities. The Subcommittee believes that the elimination of health disparities can be achieved through education, awareness building, State legislative mandates and assigned Leadership to prioritize and address the following strategies:

- Expand health care workforce development and retention initiatives to address shortages in health care professionals, including an increase in minority professionals;
- Increase funding for education programs and providers;
- Remove barriers that interfere with access to quality health care to include mental health services;
- Improve collaboration and linkages with existing community assets for a responsive and efficient health care delivery system; and
- Enhance access and capacity through innovative strategies such as telemedicine/telehealth and patient centered medical homes.

Additionally, to achieve the most beneficial outcomes will require system changes that incorporate more consistent consumer involvement, education, tracking of health care performance measures and other quality information. An effective health system integrates roles, responsibilities, and tools in the routine delivery of preventive care. Individual responsibilities are defined, the flow of activities is specified, and performance is measured. A system must have an "owner" or champion, a group of individuals who will take responsibility for its implementation, and monitoring of outcomes. (Frame, 2000).

In keeping with the definition of a system the Subcommittee recommends the creation of a *Governor's Interagency Council on Health Disparities* (GIACOHD) to provide general oversight and serve as an advocate to ensure that strategies, recommended by the Governor's Task Force to Eliminate Disparities and the respective Sub Committees are implemented within a reasonable period of time. The (GIACOHD) is viewed by the Subcommittee as both an advocate for populations burdened by health disparities and as

an agent for system change should be directed to create a state wide action plan consistent with the recommended goals and include the following concepts:

- access to health care for the uninsured and underinsured;
- social determinants that serve as obstacles to quality and equitable health care services;
- consistent standards and support for delivery of preventive and mental health care services;
- a well trained and diverse workforce to serve as consultants and provide technical assistance to State workforce initiatives;
- funding to support the recommended goals;
- delivery of evidence-based clinical preventive services to help keep people healthy and save lives;
- increase availability of culturally and linguistically appropriate health education materials and interpretive services;
- use of technology enabled services such as telehealth/telemedicine as a vehicle to increase access to care for rural providers and patients;
- And, remove barriers blocking integration of preventive health as a routine part of patient care and community services.

Further the Subcommittee encourages the promotion of communication and collaboration among state agencies, communities of color, and the public and private sectors to address health disparities; and to gather information through public hearings, research/studies, and other efforts to determine additional actions needed by state government to assist in the amelioration of factors contributing to a lack of health care access, availability equity and health disparities. Critical success factors include:

- Creation of a prioritized action plan in response to existing gaps and barriers in services and resources;
- Development of performance and evaluation measures for tracking and monitoring outcomes, and analyzing overall impact of changes;
- Integration of recommendations generated from other task forces and committee initiatives addressing health disparities and the social determinants of health care;
- Communication and collaboration among groups addressing similar issues and
- Progress reports on accomplishments.

Background

The Health Access/ Availability and Equity Subcommittee seeks to address health disparities in Oklahoma through its vision of assuring that all Oklahomans have access to equitable, affordable and quality health care homes. This vision not only embraces the concept of the treatment of illness, but also supports comprehensive, coordinated and culturally sensitive and linguistically appropriate health care; health promotion, wellness, and disease prevention education. Health care access and health equity are the two major vehicles that support the vision of the Subcommittee in addition to improving the health care delivery system capacity for those most in need.

Health care access is a topic generally intertwined with discussions around health disparities both at the State and National levels. Due to the variation in definitions and scope, the Subcommittee on health care access and equity adopted the following definition of health care access– "an individual's or population's ability to obtain health care services as demonstrated by the individual's or population's potential or opportunity to enter a health care system".

Health care access alone does not guarantee wellness or positive health outcomes. Nationally, access to health care has been determined to be problematic for vulnerable populations as the number and proportion of persons going without or delaying needed medical care increased from 36 million in 2003 to 59 million in 2007. This includes both insured and uninsured persons, persons with various health conditions, and low-income children.

Additionally, the report suggests rising out-of-pocket health costs, health plan rates and health system barriers (i.e., physician shortages) are to be viewed as problems. Health care access issues are highlighted most prominently when barriers exist. Such barriers may be categorized as

- *Structural Infrastructure* (availability, transportation, how organized);
- *Financial* (insurance coverage, reimbursement levels, public support);
- *Personal* (acceptability, cultural, language, attitudes, education/income).

Further, barriers to health care produce "inequitable circumstances" for poor and certain minority populations who generally have low socio-economic status and poor health. These populations are identified as having difficulty in getting services and having difficulty in receiving quality care. (National Academies Press, "Access to Health Care in America", 1993, Institute of Medicine)

A concept closely tied to health care access is health equity, which is defined by the Subcommittee as, "the absence of differences and barriers in the ability of individuals or populations to reach and maintain their health potential. Health equity is also viewed as having moral and ethical dimensions by attempting to create equal opportunities to health." - (Health Development Agency, "Addressing Inequities through Health Impact Assessment", 2003).

Health equity has also received considerable attention as a health disparity topic both nationally and locally as it addresses the social determinants of health. This includes issues that impact health such as education, poverty, racism, housing, etc. A 2008 World Health Organization report on the Social Determinants of Health states, "that the conditions of daily life must be improved to impact health disparities." – (WHO Commission on Social Determinants, "Closing the Gap in a Generation", 2008). Subsequent studies on the world health systems suggest even in the absence of health care access barriers, through the use of a universal health care system, differences in access to care differed by social class. Factors such as environmental control, poverty, literacy, education and occupational safety all contribute to the health status of populations – (National Academies Press, 1993). Finally, in a testimony to the 2008 Oklahoma Health Care Task Force, it was stated that genetics, environment and social circumstances contribute to health status. (Ecap New, August 12, 2008).

In a review of Oklahoma's health care landscape, several items deserve mention with regard to health care access and health equity. Oklahoma continues to rank poorly in health status and outcomes. According to a 2008 United Health Foundation report, Oklahoma ranked 43rd down from 47th in 2007; Oklahoma also continues to have a high uninsured population approaching 700,000 in 2009; and is burdened by a shortage of primary care physicians and nurses (Oklahoma Physicians Foundation, 2008); and a decrease in physician reimbursement (News OK, "Medical Crisis Awaits, July 7, 2008); and specifically, large agencies such as the Oklahoma State Department of Health (Tulsa World, "Health Agency in Budget Crisis", September 12, 2008), and the Oklahoma Department of Human Services (Ecap News, September 23, 2008) are forced to reduce services because of the shrinking pool of health care workers, decreasing revenue and increasing program and administrative costs.

Finally, a 2005 report highlighting reproductive health issues for racial and ethnic minority women in Northeastern Oklahoma found that cultural biases, stigmatization, lack of rural health care, traditional service hours, and immigration fears were barriers to health care access and quality of care, (Community Council of Tulsa, "Racial and Ethnic Minority Women in Northeastern Oklahoma: Assessment of Reproductive Indicators", 2008).

Several high profile groups, The House Health Care Reform Task Force, the State Coverage Initiative Team and the Oklahoma Health Care Authority Board, have met in recent months to address health care access, equity and availability. Their findings are consistent with of this Subcommittee to include: (1) provide financial incentives to encourage personal wellness, to develop community health care workers, and to adopt and promote the medical/health home model; and (2) modify state law allowing more workers and employers to qualify for a state-sponsored employer insurance program.

Purpose

To ensure all Oklahomans have access to equitable, affordable, culturally relevant/linguistically appropriate, and quality patient centered Health/Medical homes that address not only treatment of illness but includes comprehensive and coordinated health care, health promotion, wellness, and disease prevention education.

Key Recommendations

I. The subcommittee on Health Availability and Equity recommends the ***immediate*** creation of a Governor's Interagency Council on Health Disparities (GIACOHD), (modeled after the Governor's Interagency Council on Health Disparities – Olympia, Washington, www.healthequity.wa.gov.), to ensure continuing progress of the work and implementation of recommendations. The recommended goals must be addressed in a timely manner along with plans for sustainability; for performance tracking and measurement of outcomes; and for impact analysis on the populations at risk. (See Appendix B: Recommended Composition of the Governor's Interagency Council on Health Disparities)

I. A The Subcommittee on Heath Availability and Equity recommends the GIACOHD work to address in a responsible and accountable manner the following goals:

- Increase Health Care Access
- Increase awareness of health disparities in Oklahoma.

II. The Subcommittee further recommends the GIACOHD consider the following strategies to achieve the indentified goals:

1. Convene a group of Community stakeholders involved in similar initiatives to address the recommendations;
2. Ensure solutions/models considered for adoption are examples of evidenced based practices;
3. Develop a performance based evaluation plan with standardize measures for ongoing improvement;
4. Track, monitor, and analyze qualitative and quantitative outcomes; and
5. Advocate for public policies that positively impact statewide health disparities.

We further recommend the (GIACOHD) explore best and promising practice models for adoption that are proven to increase health care capacity, access/availability and equity for vulnerable populations. Models considered for change must have demonstrated effectiveness in:

- Eliminating barriers that block access to quality health care services,
- Addressing the social determinates (inequities/inequalities) of health care that currently impact the health status of the citizens of Oklahoma

- Integrating culturally sensitive/relevant behaviors and activities in all areas of healthcare practices,
- Planning strategies to improve poverty, health literacy, workforce and economic issues within communities.

The subcommittee is convinced that the elimination of health care disparities is a possibility provided the issues identified in this report are prioritized and addressed according to the recommendations.

Integrated Data Subcommittee Recommendations
Working Outline

Overview

The health status of Oklahomans continues to decline. National measures place Oklahoma at or near the bottom of all major indicators with little sign of improvement since the mid to late 1980's. Some of these indicators include: 50th in the nation for deaths due to heart disease, continued high levels of tobacco use with 25 percent of Oklahoma's population reporting smoking cigarettes, alarming rates of obesity, and decreasing numbers of Oklahomans who engage in regular exercise. Of particular concern, though, are pockets of Oklahoma's population that are disproportionately overburdened by these grim health status indicators.

In order to address health disparity concerns, the Oklahoma Legislature established the Oklahoma Task Force to Eliminate Health Disparities, which produced an initial set of recommendations in 2006. Formed in 2008, the new Governor's Task Force for the Elimination of Health Disparities is a continuation of efforts designed to address conditions within Oklahoma that contribute to health measures at levels significantly below those of other states within our region. Those conditions are creating identifiable health disparities within the populations of Oklahoma. The Task force has established three target areas:

- Data Integration
- Health Availability and Equity
- Informed Public

Current Oklahoma Data Systems

In July 2006, the original Oklahoma Task Force to Eliminate Health Disparities published a final report with three recommendations. In addition to cultural competency training and better health access, the original Task Force recommended the development of a standardized statewide, integrated data collection system for the use in clearly understanding and addressing health disparities and for tracking the effectiveness of intervention strategies. The 2008 Governor's Task Force for the Elimination of Health Disparities adopted the integrated data collection system recommendation as one of its focus areas and has outlined in this report a roadmap for accomplishing this critical objective. *Therefore, the mission of the Data Integration Subcommittee is to help eliminate health disparities in Oklahoma by recommending the steps toward developing and implementing an integrated data warehouse of person-specific data that promotes the understanding of factors impacting all health indices.*

Disparities are created not by one single factor or contributing cause but as a result of numerous events which, when combined, result in outcomes that significantly impact a

person's short-term and long-term health. State agencies have a variety of data collection systems enabling the analysis of information collected about those seeking services. This information is used to track the effectiveness of programs currently in place, plan future projects, guide policy makers and educate the public. Health disparities in Oklahoma can be documented through those data systems, but are often characterized and described from the perspective of the agency gathering the data. As identified in 2006, an example of a health disparity currently identified through Oklahoma data systems is breast cancer deaths among African American women. Even though the incidence for breast cancer is lower among African American women compared to white women, African American women are diagnosed at later stages and subsequently die from breast cancer at higher rates. This fact, while indicating a population which should be targeted with intervention strategies, does not identify contributing social determinants. Data which would more clearly define factors contributing to health indicators are stored in isolated yet to be linked data systems.

State agencies in Oklahoma have silos of data about clients/patients seeking services from them. Those silos serve the needs of the parent agency, but contribute little to the global understanding of health disparities in Oklahoma. This segregated data collection has been identified as a barrier to identifying those common factors that work together to amplify poor health outcomes among the population of Oklahoma. Existing as separate and distinct sets of data, state agencies analyze information in a vacuum void of the benefit gained by understanding the synergy of various influences upon health. This gap in knowledge prevents the identification of root causes for poor health outcomes within communities. Using the African American breast cancer example, the silo nature of Oklahoma's data systems prevent us from understanding why African American women are diagnosed at later stages of the disease. Is there a lack of access to screening and detection, a lack of access to treatment, or a lack of health care coverage? Data that exist in silos prevent us from answering these and other questions.

Silos of data also hamper the ability to compete for federal and private dollars since the opportunity to leverage a combined understanding of issues affecting health at the person-level is lost. Silos of data are a leading factor in the duplication of effort across agencies resulting in wasted resources and unnecessary competition for limited dollars.

In summary, there are numerous data-specific factors that contribute to health disparities in Oklahoma. Among them are:

- Independent silos of data that do not communicate across fellow agencies and prevent holistic views of state populations and frustrate the involvement of citizens in designing strategies.
- A universal lack of understanding of what data is collected by state agencies, leading to duplication of data collection, data redundancy with state agencies and uninformed decision making.
- Data collection methods which prevent the systematic aggregation of data and lead to fractured views of where to place intervention and prevention strategies.

- A universal lack of documented data collection and utilization policies and strategies by Oklahoma state agencies.
- A lack of searchable web-based databases of what variables are gathered on clients/patients.
- An over reliance upon federal interpretation for planning and developing data collection tools and databases contributing to dependence upon design strategies that primarily address national not local priorities.

Key Recommendation

State Data Dictionary as First Step Toward an Integrated Data System

The elimination of health disparities in Oklahoma will not occur through any single action, but only though multiple significant events. Developing a clear foundation from which decisions are made grounded in quality data is one such advancement necessary for eliminating health disparities and signals the type of event that will result in long-term health improvement. It is strongly recommended that the Governor adopt the following recommendations and establish an Executive Order directing Oklahoma State Agencies to comply.

The Data Integration Subcommittee of the Governor's Task Force for the Elimination of Health Disparities makes the following recommendations:

1. Through executive order, the Governor of Oklahoma establishes the Oklahoma Data Dictionary Clearinghouse. The Oklahoma Data Dictionary Clearinghouse will be a web-based, searchable statewide data dictionary initially hosted through the United Way of Central Oklahoma (or similar independent, non-governmental organization). The United Way would serve as a neutral location for initiating the Clearinghouse addressing concerns that a single state agency would hold more knowledge than others and would serve as a reminder for the need to have communities included in the decision making process.
2. The Governor of Oklahoma establishes the Oklahoma Data Dictionary Clearinghouse Oversight Committee that would develop rules for accessing, using, aggregating, and reporting data variables housed in the web-based data dictionary. This Committee will be an outgrowth of the Data Integration Subcommittee and will develop recommendations for prioritizing data variable collection under groupings contributing directly and indirectly to the calculation of current health indices. Members on the oversight committee should represent all contributing state agencies, Oklahoma City-County Health Department, Tulsa County Health Department, representatives from the Governor's Task Force for the Elimination of Health Disparities, and representatives of clients/consumers served by each contributing agency.
3. The Governor of Oklahoma directs state agencies to develop listings of all data variables collected by internal programs or projects and provide that state agency data variable list to the United Way of Central Oklahoma.

4. The Governor of Oklahoma directs the establishment of resources for long-term sustainment of the Oklahoma Data Dictionary Clearinghouse.
5. The Governor of Oklahoma requires all state agencies to participate in the Oklahoma Data Dictionary Clearinghouse.

Steps Toward Establishing an Oklahoma Integrated Data Warehouse

The goal of the Health Disparities Task Force Data Integration Subcommittee is to see the establishment of an Oklahoma Integrated Data Warehouse as the initial step toward establishing an integrated public health information center. This step would ultimately lead to the creation of an integrated public health information system designed for the purpose of supporting the public health functions of assessment, policy development and assurance. Outcomes include decreasing duplication of data collection efforts, improving data quality, and increasing access to the information providing the background needed to make informed decision-making. A functional data warehouse would provide better understanding of unrecognized factors that exist across programs and populations at the local and state level which ultimately contribute to the health disparities of today as well as identifying future factors which might create health disparities of tomorrow.

Phase I – Step A – Data Dictionary
Establish the Oklahoma Data Dictionary Clearinghouse Oversight Committee to assure the inclusion and reporting of appropriate data. Recommended variables might include:

A. Socio-Demographic Measures
1. Demographic measures (age, race, ethnicity)
2. Socio-economic position (education, occupation, income)
3. Location of residence (county, zip code)
4. Acculturation (proxies include primary language, place of birth, time and generation in the United States)
5. Crime
6. Transportation
7. Housing
8. Occupation
9. Distribution of Resource

B. Health Care Access and Quality Measures
1. Health insurance status
2. Health care utilization
3. Health care process indicators

C. Health Status Indicators
1. Risk factors
2. Morbidity
3. Mortality
4. Injury
5. Chronic Disease

6. Infectious Disease
7. Cancer

Additionally this Committee would develop rules and procedures for assuring local communities have access to the data. The committee would be a forum for project developers to exchange information and best practices, and serve to educate others who will benefit from having access to the data when developing intervention strategies designed to eliminate health disparities.

Phase I – Step B – Data Dictionary:
As described under the Key Recommendation, the Health Disparities Task Force Data Integration Subcommittee recommends the development of a data dictionary clearinghouse. This dictionary should exist as a web-based searchable collection of variable names, formats, descriptions and uses collected by Oklahoma State agencies related to data collected about Oklahoma residents. The database should contain a listing by agency of each variable gathered, the program that gathers the variable and a contact person with job title within that program. Access to the web-based dictionary would be available to state agencies, universities, and others interested in moving toward an Oklahoma Integrated Data Warehouse, with access policy determined by an oversight committee appointed by the Governor. This dictionary would not contain person specific data, but only the variable name and a description of that variable.

Phase I – Step C – Data Dictionary:
Adequately support the efforts of state agencies as they improve data collection and reporting infrastructures to allow participation in the Oklahoma Data Dictionary Clearinghouse. This should include development of meaningful data analysis for the measurement of health disparities throughout the State by all Agencies. Support small demonstration projects at the local level to provide insight into data collection and reporting methods that may prove successful statewide.

Phase II – Step A – Data Warehouse:
Support the development of a statewide, unique person identifier method that protects the privacy of individuals and aids in data matching across participating agencies. An example of such an identifier might be:

Initials-gender-date of birth-last 4 digits of social security number (male, use last name initial; female, use maiden name initial)

Phase II – Step B – Data Warehouse:
The Health Disparities Task Force Data Integration Subcommittee recommends supporting the development of an integrated data warehouse of person-specific data collected on Oklahoma residents by Oklahoma State agencies. This data warehouse would represent the most comprehensive statewide knowledge base on direct and indirect factors impacting health measures at the person level. The design, development, testing and implementation would be conducted by a designated entity responsible for the development of business rules such as access, security, data suppression and levels of

aggregation determined by an oversight committee, and would be managed by an organization designated by the oversight committee.

Future Recommendations

The establishment of the Oklahoma Data Dictionary Clearinghouse will signal a point in history where true recognition of all factors contributing to health disparities could be known. However, the Clearinghouse alone is but one component necessary for the removal of health disparities. While newly developing technology will redefine approaches, the 2008 Governor's Task Force for the Elimination of Health Disparities is making additional recommendations as next steps in developing a global understanding of issues, which result in disparities affecting health:

- Create and maintain a searchable, Web-based data portal that contains descriptions and links to datasets and related resources and allows or supports the creation of customized reports.
- Explore availability of data from community-based groups and faith-based organizations and the role these data can play in understanding health disparities at the community level. Investigate the potential for collecting measures in order to produce analysis that will promote the understanding of geographic, racial and ethnic health disparities at the person level.
- Collect and report data on health care access, health care utilization, and health care system performance by patient's race, ethnicity, socio-economic status, and where possible, primary language.
- Collect representative survey information that provides information on provider and patient attitudes and beliefs regarding health care. Include questions that allow respondents to additionally identify how they believe their race and ethnicity are perceived by the health care system.
- Finally, agencies should collect data to monitor the progress toward elimination of health disparities, and study the impact of program interventions on minority populations by tracking the exposure to the intervention and measuring intermediate and ultimate health outcomes.

APPENDICES

Appendix A – Suggested Strategies for Goal Achievement

Goals:

1) Increase health care access for Oklahoma populations at risk for complications related to chronic disease.
   Suggested Strategies:

   - Research examples of evidence based and promising practices health care delivery models for potential replication in Oklahoma. Models should:
     1. be population based targeting individuals most at risk
     2. use creative approaches in chronic disease management
     3. ensure timely, culturally relevant quality health care delivery for at-risk populations
     4. integrate the use/expansion of telehealth/medicine technology

     See – Centers for Disease Control and Prevention (CDC) – Reach Project the Power to Reduce Health Disparities – Voices from Reach Communities.
   - Collaborate with and leverage the work of organizations seeking to address health care education and capacity building which includes recruitment and retention of a culturally diverse health care workforce.

2) Increase awareness of health disparities in Oklahoma.
   Suggested Strategies:

   - Collaborate with Oklahoma State Department of Health's - Health Equity Resources Office campaign to bring attention to the social determinants of health, specifically impacting Oklahoma's communities of color facing examples of the following issues such as but not limited to – poverty, illiteracy, lack of education access, unemployment, environmental issues.

Appendix B – Recommended Composition of the Governor's Interagency Council on Health Disparities (GIACOHD)

Representatives from:

- State Level Agencies
- Workforce development
- Higher Education
- Health Care Providers and Professional Organizations
- Business Community
- State Based Coalitions/Initiatives
- State Minority/Ethnic Associations
- Minority/Ethnic Community Based Organizations
- Faith Based Organizations
- Community Stakeholder

Appendix C – Glossary – Concepts Defined

Access:

An individual's ability to obtain needed health care services. Access is also the potential or actual entry of an individual or population into Oklahoma's healthcare system

Adult Literacy:

The ability of an individual eighteen (18) years of age or older to read and write in the primary language used in health care environments

Availability:

Health care services and resources that are readily accessible and can be obtained in a timely manner by those in need

Capacity:

Generally denotes size, magnitude, and proportion. In terms of eliminating health disparities, it has both individual and systems applications that is analogous to "ability". With individuals, capacity is an individuals' ability to meaningfully and timely access needed, high quality health care services. When used in reference to systems, capacity refers to the systems' ability to adapt and expand health care services in response to increased and ongoing demand.

Cultural Competence:

Congruent behaviors, attitudes, and policies that come together in a system, or agency; or among professionals enabling effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behaviors that include the language, thought, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization with the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.

Cultural competence of health care professionals includes the ability to:

- Apply knowledge of social and cultural factors affecting health professions and the provision of health care services across settings;
- Use relevant data sources and best evidence in providing culturally competent care;
- Promote achievement of safe and quality outcomes of care for diverse populations;
- Advocate for the elimination of health disparities and for the delivery of health care services to vulnerable populations; and
- Participate in career-spanning cultural competence development

Determinants of Health Status:

Healthy people 2010 suggests that population health is determined by a complex interaction of multiple factors, including but not limited to individual behavior, biological factors, physical and social factors (including but not limited to poverty, under- and un-insured, homelessness, absence of effective and efficient transportation, geographic isolation and joblessness) environmental factors, policies, interventions and access to heath care services.

Effectiveness:

Outcomes of the delivery of health care services that are measured by health improvement.

Efficiency:

Relationship between health improvement and the resources required to produce them.

Health (Primary) Care Home:

Sometimes referred to as a "medical home", a health care home is a central and community-based source for comprehensive, coordinated and continuous chronic disease, wellness and primary care management. Fully operational, health care homes deploy multidisciplinary health care services that contribute to the health and well-being of individuals and alleviate non-emergent care provision in emergency rooms.

Health Care Workforce Development:

Ensuring that there is an adequate supply of multicultural primary health care professionals, including physicians, registered nurses, pharmacists and other allied health professionals to provide health care services to all Oklahomans, including underserved and vulnerable populations.

Health Disparities:

According to the National Institute of Health disparities is the difference in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific population groups in the United States. Research suggests issues of social inequality are involved and must be addressed before differences in health outcomes among racial and ethnic groups can be eliminated.

Health Equity:

The absence of differences and barriers in the ability of individuals to reach and maintain their greatest health potential

Health Literacy

The degree to which individuals have the capacity to obtain, process, and understand basic information and services needed to make informed decisions regarding their health.

Limited English Proficiency:

Persons who have difficulty, speaking, reading, writing, or understanding the English language

Poverty:

A calculation used by the U.S. Census Bureau and other governmental agencies to detect the incidence of impoverishment. Variables used in the calculation are annual family income, family size and number of children under the age of eighteen (18), among others. The calculation yields annually adjusted percentage of poverty threshold data that is used to determine the incidence of impoverishment nationwide, and on a state-by-state basis.

According to 2007 calculations released by the U.S. Census Bureau, nearly one (1) in six (6) Oklahomans was living in poverty. In addition, Oklahoma's poverty rate was 2.6% percentage points higher than the national average.

Telehealth:

Using telecommunications technology to provide disease prevention, health promotion, health education, administrative and program planning services

Telemedicine:

Using telecommunications technology to provide clinical services, diagnosis and consultation

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