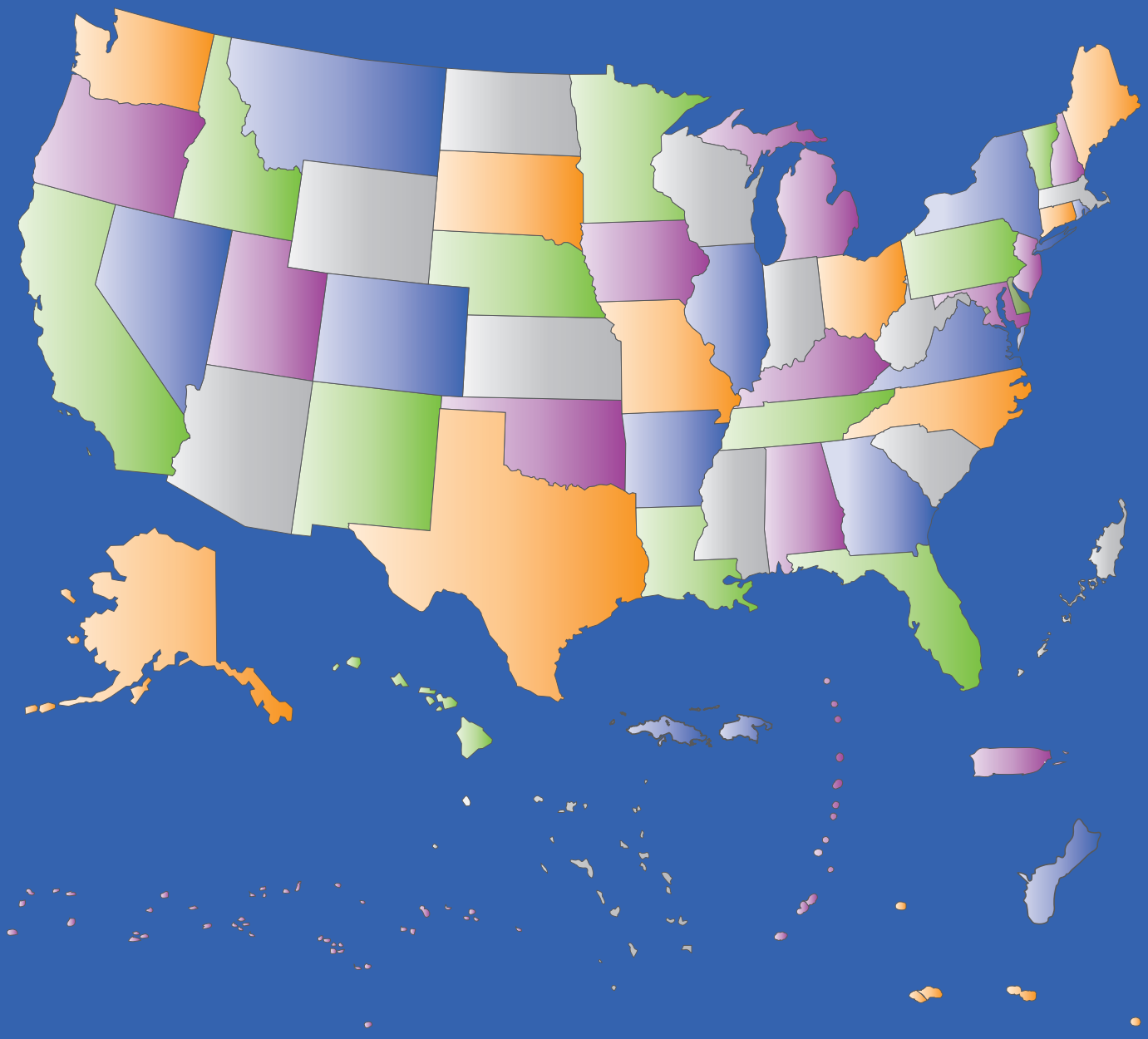
# State and Territorial Efforts to Reduce Health Disparities

Findings of a 2016 Survey by the U.S. Department of Health and Human Services Office of Minority Health



OMH U.S. Department of Health and Human Services Office of Minority Health

# State and Territorial Efforts to Reduce Health Disparities

Findings of a 2016 Survey by the U.S. Department of Health and Human Services Office of Minority Health

This document was produced for the Office of Minority Health by Westat under contract number **HHSP23320095655WC**, order number **HHSP23337028T**. The contributing authors were: Sari Siegel, Brenda Leath, Stephanie Fry, Calvin Pierce, Natalie Teixeira, Willow Burns, Nina Freed, Paul Weinfurter, Brian Dorsey, and Jennifer Nooney of Westat, and Stacey Williams of the Office of Minority Health. The views expressed in this report are those of the authors and do not necessarily represent those of the Office of Minority Health, U.S. Department of Health and Human Services.

**Suggested citation:** U.S. Department of Health and Human Services, Office of Minority Health. (2018). *State and Territorial Efforts to Reduce Health Disparities: Findings of a 2016 Survey by the U.S. Department of Health and Human Services Office of Minority Health.* Washington, DC: U.S. Department of Health and Human Services.

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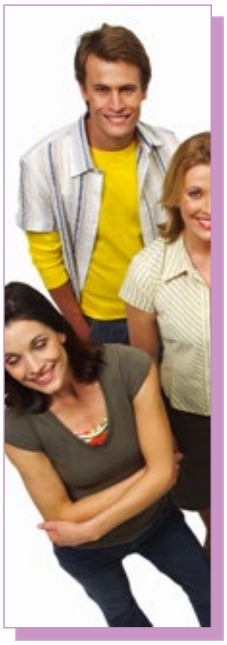







# Letter from OMH Director

July 29, 2018

On behalf of the United States Department of Health and Human Services (HHS) Office of Minority Health (OMH), I am delighted to present our special report, **State and Territorial Efforts to Reduce Health Disparities (Health Disparities Report)**. This report summarizes persistent health disparities in the United States, as well as innovative state-level approaches to address them. The strategies used and reported by the states draw upon evidence-based strategies, frameworks, and models proven through decades of independent research and practices.

As you peruse the following pages, you will learn about the OMH's long-standing history of developing and implementing strategies designed to build and strengthen partnerships across public and private sectors for the purpose of improving the health status of racial and ethnic minority populations. Often the coordination of activities addressing health disparities and health equity occur at the state level within the organizational units that focus on minority health issues. These organizational units, or state/territory minority health entities (SMHEs), have been principal partners in linking the OMH (and other federal agencies) and local efforts to address and eliminate racial and ethnic health disparities.

The Health Disparities Report is the culmination of commitment and hard work from multi-sector stakeholder entities. Dissemination of this resource, particularly to community-level decision-makers, represents an important step toward increasing the accessibility of state- and territory-level data to a wide range of audiences. This data sharing supports opportunities to achieve the goals of the 2018–2022 HHS Strategic Plan, such as meaningful health system reform. It also supports national health policy that will improve population health. As such, this publication will be of great interest to funders, legislators, researchers, and institutional administrators, among other stakeholders.

I encourage all current and emerging OMH partners, organizational networks, community coalitions, multidisciplinary professionals, and others working to eliminate health disparities to consult and use this report in your ongoing work. The OMH and its constituent organizations are energized by our collective successes and are committed to furthering our mission to achieve health equity. We hope you will explore this defining report and visit our website to learn more about our successes to date and share our vision for the future.

Sincerely,

Matthew Y.C. Lin, MD
Deputy Assistant Secretary for Minority Health
and Office of Minority Health Director

# About the Federal Office of Minority Health and State and Territorial Minority Health Entities

## Background on the Office of Minority Health

Understanding the background and history of the Office of Minority Health (OMH) is critical to a productive review of the agency's body of work, including initiatives and resulting impacts. OMH's portfolio of projects and resource materials such as reports, tools, and peer-reviewed literature provides essential context. This background information lends clarity and perspective to its vital mission, signature initiatives, stakeholder engagement strategies, and multi-level partnerships. Of particular relevance to this report are the OMH partnerships with state and territorial offices, which align with the OMH National Partnership for Action to Eliminate Health Disparities (NPA) and the National Stakeholder Strategy for Achieving Health Equity.

The National Institutes of Health defines health disparities as "differences that exist among specific population groups in the United States in the attainment of full health potential that can be measured by differences in incidence, prevalence, mortality, burden of disease, and other adverse health conditions.[1] Disparities are often used within the context of two social constructs—race and ethnicity; however, they can also occur within the contexts of gender, sexual orientation, age, disability status, socioeconomic status, and geographic location.[2] According to Healthy People 2020, all of these factors, in addition to race and ethnicity, shape an individual's ability to achieve optimal health.[3]

OMH's etiology resulted, in part, from a landmark 1985 report released by the United States Department of Health and Human Services (HHS) entitled "The Secretary's Task Force Report on Black and Minority Health" (Heckler Report). The Heckler Report offered a stark and compelling account of the prevalence of health disparities among racial and ethnic minorities in the United States. This defining work led to the elevation of minority health to national priority status and the establishment of the OMH in 1986.

In 2010, the Patient Protection and Affordable Care Act (ACA) reauthorized OMH, further solidifying its structure within the federal landscape. This statute also mandated the establishment of Offices of Minority Health within six HHS agencies: Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, Food and Drug Administration, Health Resources and Services Administration, and Substance Abuse and Mental Health Services Administration.

These subsequently established federal Offices of Minority Health join the HHS Office of Minority Health and the National Institute on Minority Health and Health Disparities (NIMHD) to lead and coordinate activities geared toward improving the health of racial and ethnic minority populations and eliminating health disparities. This configuration resulted in a formidable interagency partnership that supports federal efforts to end health disparities and promote health equity.

1 NIH (National Institutes of Health). Health disparities. 2014. [November 2, 2016].http://www.nhlbi.nih.gov/health/educational/healthdisp.

2 National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Communities in Action: Pathways to Health Equity, Baciu A, Negussie Y, Geller A, et al., editors. Washington (DC): National Academies Press (US); 2017 Jan 11.

3 Healthy People 2020. Healthypeople 2020. 2016. [October 21, 2016]. https://www.healthypeople.gov.

The work of OMH, NIMHD, and HHS agency Offices of Minority Health is conducted in support of the 2018–2022 HHS Strategic Plan and its five identified goals:

- Reforming, Strengthening, and Modernizing the Nation's Healthcare System
- Protecting the Health of Americans Where They Live, Work, Learn, and Play
- Strengthening the Economic and Social Well-Being of Americans Across the Life-Span
- Fostering Sound, Sustained Advances in the Sciences
- Promoting Effective Management and Stewardship.

## OMH's Mission

OMH's mission is to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities. Racial and ethnic minorities continue to lag behind other populations in many health outcome indices.[4] Racial and ethnic minority populations are less likely to obtain preventive services, less likely to have access to quality health care, and more likely to suffer from serious illnesses than their non-minority.[5] Health disparities among racial and ethnic minority populations may be found in geographical hotspots: areas with high disease prevalence or behaviors that put people at risk for acquiring a disease. Moreover, health disparities among racial and ethnic minority groups are often linked to social, economic, or environmental disadvantages,[6,7] such as:

- Poor access to health care service
- Concentrated poverty
- Inadequate education and job opportunities
- Exposure to crime and violence
- Unsafe housing
- Insufficient access to affordable healthy foods
- Limited transportation options.

These social, economic, and environmental conditions that impact the way people live and work are known as social determinants of health. OMH programs, policies, and practices address such factors, with the goal of affording everyone an opportunity to live a long, healthy, and productive life, and to improve the overall quality of life for the nation as a whole.

## OMH's Structure and Core Functions[8]

OMH is housed in the Office of the United States Secretary for Health and Human Services. The dually appointed Deputy Assistant Secretary for Minority Health and Director of the Office of Minority Health provides executive leadership for the OMH and is supported by an interdisciplinary team of policy, program, and administrative staff.

The OMH's core functions are to:

- Promote the collection of health data by racial, ethnic, and primary language categories and strengthen infrastructures for data collection, reporting, and sharing
- Work to increase public awareness of the major health problems of racial and ethnic minorities and factors that influence health through collaborations and partnerships
- Establish and strengthen networks, coalitions, and partnerships to identify and solve health problems
- Develop and promote policies, programs, and practices to eliminate health disparities and achieve health equity
- Foster research, demonstrations, scientific investigations, and evaluations aimed at identifying and addressing health disparities
- Fund demonstration programs that can inform health policy and the effectiveness of strategies for improving health disparities.

4 Centers for Disease Control and Prevention. CDC Health Disparities and Inequalities Report — United States, 2013. MMWR. 2013;62 (Suppl 3):1-187. Available at: https://www.cdc.gov/mmwr/pdf/other/su6203.pdf.

5 Artiga S, Foutz J, and Cornachione E, and Garfield R. (2016), Key Facts on Health and Health Care by Race and Ethnicity. Kaiser Family Foundation. Available at: https://www.kff.org/disparities-policy/report/key-facts-on-health-and-health-care-by-race-and-ethnicity/.

6 Sealy-Jefferson S, Vickers J, Elam A, and Wilson, MR. Racial and Ethnic Health Disparities and the Affordable Care Act: A Status Update. Journal of Racial and Ethnic Health Disparities. 2015. 2(4):583-588.

7 Lancaster KJ and Bermudez OI, Beginning a discussion of nutrition and health disparities. The American Journal of Clinical Nutrition. 2011;93(5):1161S-1162S. Available at: https://academic.oup.com/ajcn/article/93/5/1161S/4597882.

8 Office of Minority Health U.S. Department of Health and Human Services. Available at, https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=4.

## About the Federal OMH and State and Territorial Minority Health Entities

OMH programs address disease prevention, health promotion, risk reduction, healthier lifestyle choices, use of health care services, and barriers to health care. OMH accomplishes its work through a multi-tiered approach to coordinate HHS health disparity programs and activities.

These core functional areas involve assessing policy and programmatic activities for health disparity implications; building awareness of issues impacting the health of racial and ethnic minorities; developing guidance and policy documents; collaborating and partnering with agencies within HHS, across the federal government, and with other public and private entities; funding demonstration programs; and supporting projects of national significance.

OMH established the National Partnership for Action (NPA)[9] in 2007 to mobilize a nationwide, comprehensive, community-driven, and sustained effort focused upon combatting health disparities and achieving health equity. NPA's mission is to increase the effectiveness of health disparity elimination efforts by coordinating efforts to address social determinants of health (SDoH) and facilitate a heightened awareness of the role of SDoH in health care disparities. NPA's work is guided by five goals listed in Figure 1.

### Figure 1. The Five NPA Goals[10]

**Goal 1: Awareness** – Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial and ethnic minorities and other underserved populations.

**Goal 2: Leadership** – Strengthen and broaden leadership for addressing health disparities at all levels.

**Goal 3: Health System and Life Experience** – Improve health and healthcare outcomes for racial and ethnic minorities and other underserved populations.

**Goal 4: Cultural and Linguistic Competency** – Improve cultural and linguistic competency and the diversity of the health-related workforce.

**Goal 5: Data, Research, and Evaluation** – Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes.


The NPA expands OMH's capacity and infrastructure for implementing the OMH programs and initiatives. As shown in Figure 2, the NPA engages multi-level partnerships to support its implementation structure. These strategic partnerships leverage individual and collective resources to increase their effectiveness and produce mutually beneficial outcomes across multiple levels and sectors. The NPA is implemented at the federal level through the Federal Interagency Health Equity Team (FIHET) and regionally through 10 Regional Health Equity Councils (RHECs). The FIHET is comprised of 12 federal agencies, and the RHECs are non-federal coalitions including volunteer members from academia, government, and the private sector. National partners leverage resources and expand reach and network (National Indian Health Board, National Conference of State Legislatures, Association of State and Territorial Health Officials, and DentaQuest). State offices of minority health (SOMHs) work at the state level to align policies and programs with the NPA and with local and national partners to promote health equity in their communities. SOMHs serve as conduits between RHECs and state and local coalitions. They lead the effort to align state-level health equity plans with NPA goals.

9 National Partnership for Action to End Health Disparities. Office of Minority Health, U.S. Department of Health and Human Services. Available at: https://minorityhealth.hhs.gov/npa/templates/browse.aspx?lvl=1&lvlid=11.

10 For more information, please see the OMH National Partnership for Action to End Health Disparities website.

### The Alignment of OMH's Partnerships with State and Territorial Offices of Minority Health with the Health Disparities Survey and Report

The OMH's history and organizational mechanisms provide a contextual framework for the data collection activity highlighted in this report. The OMH has maintained longstanding partnerships with state offices of minority health/health equity (or other state entity with similar function), other state agencies, tribes and tribal health agencies/organizations, and U.S. territories. These entities have been pivotal to the process of implementing the NPA.

Each partnership is unique, adding diversity and considerable value to the collective efforts aimed at reducing health disparities and promoting health equity. Importantly, such partnerships have demonstrated states' abilities to play a significant role in efficiently and effectively improving health outcomes in geographical hotspots (in communities) and addressing health disparities that affect minorities and disadvantaged populations.

The diversity of priorities among the states and territories requires an individualized approach that allows each state to systematically identify and report its current status and efforts relative to: racial and ethnic health disparities; financial resources and revenue streams; organizational infrastructure; and technical assistance requirements. The challenge to improve minority health and eliminate health disparities relies on the commitment of state and territorial health departments to continuously improve health status and find innovative ways to monitor and tackle complicated problems with limited resources and staff.

**Figure 2. NPA Multi-Level Partnerships and Implementation Structure**


## Background on State and Territorial Minority Health Entities' Relationship with the OMH

The need for reporting on state-level initiatives focused on health disparities, health equity, and minority health is based on the persistent prevalence of disparities and on the OMH's priority for enhanced access to contextualized data and information on health disparities and health equity that are embedded in state initiatives. State data and information substantiate the existence of longstanding disparities in health and health care, which continue to pose significant public health risks. Such health disparities are evident throughout the nation and continue to disproportionately burden minority, vulnerable, and other at-risk subpopulation groups. As documented by the Institute of Medicine,[11] poor health outcomes for African Americans, Hispanic Americans, American Indians and Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders are apparent when comparing their health indicators against those of the rest of the U.S. population. These populations experience higher rates of illness and death from many health conditions, such as heart disease, stroke, specific cancers, diabetes, HIV/AIDS, asthma, hepatitis B, and obesity. Such disparities in health outcomes merit systemic approaches that have the potential for achieving viable and substantive improvements. This Health Disparities Report is one of many OMH-initiated collaborations with state and territorial minority health entities promoting health equity, which play a pivotal role in promoting health equity and reducing the physical and financial costs of health disparities. Through this project, the OMH and these minority health entities collaborated to obtain data that ultimately will help inform the OMH policy and program investments. The diversity of state and territorial priorities and contexts are reflected in the profiles. From the onset, the OMH recognized the need to tailor its data collection approach to allow each state and territory to identify its unique challenges, specific racial and ethnic health disparities, financial resources, and organizational infrastructure.

11 National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Communities in Action: Pathways to Health Equity. Weinsten JN, Geller A, Negussie Y, and Baciu A (editors). Washington (DC): National Academies Press (US); 2017.

# Part I: Executive Summary

The ***State and Territorial Efforts to Reduce Health Disparities Report*** (hereafter referred to as the Health Disparities Report) was developed in alignment with HHS priorities, the Office of Minority Health's mission, and strategic priorities, including the NPA. This report provides a snapshot of each state and territory's infrastructure around health equity, disparities elimination, and minority health. It explores, in detail, the specific activities and partnerships that establish the health equity landscape in each state and territory—including available resources, existing partnerships, activities, and funding dedicated to promoting health equity. This information is synthesized into a narrative description, based upon interviews with minority health entities in each state/territory. Each profile includes standardized quantitative data elements that assess demographics and condition prevalence within each state/territory, enabling common reference points across all states and territories that help with benchmarking efforts. Detailed descriptions of the implementation of statewide initiatives to reduce health disparities in the 50 states, the District of Columbia, and four U.S. territories and/or commonwealths provide a foundation for the narrative.

State approaches employed to address health disparities and promote health equity are grounded in scientific evidence that supports the utilization of a social determinants framework as a correlate factor in successful outcomes. Foundational research has also validated innovations considered best practices, which take into consideration the socio-environmental contexts in which people are born, live, work, learn, play, worship, and age. Through OMH's partnerships with the states and territories and their contributions to this report, greater insight is provided regarding the types of innovations currently being implemented to promote health equity broadly across geopolitical regions.

The need for identifying on state-level initiatives focused on health disparities, health equity, and minority health is based on the persistent prevalence of disparities, and on OMH's priority for enhanced access to contextualized data and information on health disparities and health equity that are embedded in state initiatives. As previously stated, a report by the National Academies (Institute of Medicine) documents the many health disparities experienced by racial and ethnic minority populations. According to the 2016 AHRQ Health Healthcare Quality and Disparities Report,[12] while a small portion of measures for disparities may be decreasing for Blacks and Hispanics, most disparities have not changed significantly for any racial and ethnic group.

This State and Territorial Health Disparities Report is one of many OMH-initiated collaborations with state and territory minority health entities promoting health equity, which play a pivotal role in promoting health equity and reducing the physical and financial costs of health disparities. States and territories are well aware of the impact of disparities on individual and population health indices, as well as state and local budgetary resources. Indicators such as work and school absenteeism, service utilization, prevalence of chronic illnesses, preventable deaths, and accelerating health care expenditures are among the types of measures that illuminate how excess disease burdens affect the lives of people who are at greatest risk for poor health. *These impacts have far-reaching implications for the health and well-being of all Americans*. The intent of this effort is to obtain data that ultimately will help inform the OMH, and other federal state/territorial policy and program investments. The diversity of state and territorial priorities and contexts are represented by the profiles included in this report. The resulting profiles, therefore, reflect considerable variability in approaches to reduce health disparities.

12 2016 National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; July 2017. Agency of Healthcare Research and Quality (AHRQ) Pub. No. 17-0001.

Initiatives identified in this report comprise a range of strategies, such as:

- Health In All Policies
- CLAS implementation
- Special population interventions (e.g., increasing physical activity, promoting oral health)
- Community engagement in research—Community-Based Participatory Research (CBPR)
- Integration of health equity strategies across sectors.

The persistent disparities juxtaposed against the rich diversity in state and territorial approaches to address them underscore OMH's understanding of the perpetual challenges necessitating state and territorial health departmental commitments to continual improvement in health status. This population-centered mechanism helps to garner innovative ways to tackle complicated problems with limited resources and staff. Moreover, this invaluable report provides OMH with data and information to establish a baseline for the development and implementation of public policies as well as benchmarks that can be used to develop health equity tools such as a health equity scorecard, or report card, at the state level.

# Part II. Acknowledgements

OMH launched the ***State and Territorial Efforts to Reduce Health Disparities Report*** production process with assistance from many individuals who graciously contributed their time and expertise to this effort. In particular, we are indebted to our Technical Expert Panel, which helped us and our contractor, Westat, to reach consensus on information to include within the data collection protocol. This participatory process helped to create a tailored instrument that would inform OMH's understanding of the geopolitical contexts in which state and territorial health disparities reduction and health equity innovations were developed, funded, and deployed.

We thank the State and Territorial Offices of Minority Health for their collaboration, contributions, and support for their commitment and generous dedication of their time for participating in the interview, providing written documentation to supplement information shared during the interview, and for reviewing and providing input on the final profile.

Similarly, we extend our gratitude to the following individuals for their consultation and input on federal data sources to capture relevant contextual information about each state and territory's health equity infrastructure: Juanita Chinn (CDC/OPHSS/NCHS), Dianne Rucinski (OS/OASH), and Minh Wendt (OS/OASH).

Special thanks to the leadership of the Westat project team: Brenda Leath, Project Director; Jennifer Nooney, Project Manager; Sari Siegel, Report Task Lead; Stephanie Fry, Survey Task Lead; and Cal Pierce, Editor.

Finally, we want to recognize the individuals who directly contributed to the production of the Health Disparities Report: Carol Jimenez, JD, Deputy Director; Alexis D. Bakos, PhD, MPH, RN, Senior Advisor to the Deputy Assistant Secretary; Christine Montgomery, Senior Management and Program Analyst; and Stacey L. Williams, Regional Operations Officer, Division of Program Operations, Office of Minority Health (Contracting Officer's Representative).

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# Part II. Acknowledgements

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1. Alabama
2. Alaska
3. American Samoa
4. Arizona
5. Arkansas
6. California
7. Colorado
8. Connecticut
9. Delaware
10. District of Columbia
11. Florida
12. Georgia
13. Guam
14. Hawaii
15. Idaho
16. Illinois
17. Indiana
18. Iowa
19. Kansas
20. Kentucky
21. Louisiana
22. Maine
23. Maryland
24. Massachusetts
25. Michigan
26. Minnesota
27. Mississippi
28. Missouri
29. Montana
30. Nebraska
31. Nevada
32. New Hampshire
33. New Jersey
34. New Mexico
35. New York
36. North Carolina
37. North Dakota
38. Northern Mariana Islands
39. Ohio
40. Oklahoma
41. Oregon
42. Pennsylvania
43. Puerto Rico
44. Rhode Island
45. South Carolina
46. South Dakota
47. Tennessee
48. Texas
49. United States Virgin Islands
50. Utah
51. Vermont
52. Virginia
53. Washington
54. West Virginia
55. Wisconsin
56. Wyoming

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# Part III: Introduction & Background

The National Institutes of Health defines health disparities as "differences that exist among specific population groups in the United States in the attainment of full health potential that can be measured by differences in incidence, prevalence, mortality, burden of disease, and other adverse health conditions."[13] Disparities are often used within the context of two social constructs—race and ethnicity; however, they can also occur within the contexts of gender, sexual orientation, age, disability status, socioeconomic status, and geographic location.[14] According to Healthy People 2020, all of these factors, in addition to race and ethnicity, shape an individual's ability to achieve optimal health.[15]

The landmark 1985 report released by the United States Department of Health and Human Services (HHS), "The Secretary's Task Force Report on Black and Minority Health" (Heckler Report), offered a stark and compelling account of the prevalence of health disparities among racial and ethnic minorities in the United States. This defining work led to the elevation of minority health to national priority status and the creation of the Office of Minority Health (OMH).

Thirty-three years after the Heckler Report focused a national spotlight on the topic of disparities, health equity continues to be a pervasive national problem. Given the current population trends and trajectories, in which minority populations are an increasing proportion of the nation's residents, the persistence of disparities has never had more serious implications. The growth of those populations experiencing poorer outcomes poses significant risks to the health of all Americans—and the proportion of public dollars spent on improving health outcomes.

OMH seeks to improve the health of racial and ethnic minority populations through policy and program development that work to eliminate health disparities. Recognizing that categorical type and causation of disparities vary significantly across the country and that states have substantial responsibility for addressing population health, OMH has explicitly targeted states as an increasingly powerful vehicle in the journey to achieve health equity. OMH provided support for building capacity and infrastructure of state offices of minority health through planning contracts in the 1990s. The State Partnership Grant Program and other demonstration grant programs have also served as mechanisms through which support has been provided. Some states continue to receive support from this program, and OMH works closely on an ongoing basis with all state and territorial offices of minority health to implement federal initiatives to improve minority health and eliminate health disparities.

The ***State and Territorial Efforts to Reduce Health Disparities Report*** (hereafter the Health Disparities Report) was developed in alignment with HHS priorities, the OMH mission, and strategic priorities. This was accomplished through detailed descriptions of the implementation of statewide initiatives and programs to reduce health disparities in the 50 states, the District of Columbia, and U.S. territories and/or commonwealths. State solutions used to address health disparities and health equity are grounded in scientific evidence on the significance of using a social determinants framework. Foundational research has also validated innovations that are considered best practices, which take into consideration the contexts in which people are born, live, work, learn, play, worship, and age. Through the contributions to this report provided by representatives of the state and territorial minority health entities, we gain insights into the contexts and innovations that are being implemented to promote health equity broadly across regions.

13 NIH, National Heart, Lung, and Blood Institute. Health disparities. http://www.nhlbi.nih.gov/health/educational/healthdisp. Reviewed April 2017.

14 National Academies of Sciences, Engineering, and Medicine; Ibid.

15 Healthy People 2020. Available at: https://www.healthypeople.gov. Accessed October 21, 2016.

The need for reporting on state level initiatives focused on health disparities, health equity, and minority health is based on the persistent prevalence of disparities that varies by region. Health care disparities continue to pose significant public health risks. As discussed in an Institute of Medicine report, differential health outcomes exist across and within all of the identified population subgroups.[16] Further, scientific literature informs us of the etiology of health disparities, which can stem from health inequities—systematic differences in the health of groups and communities occupying unequal positions in society.[17,18] Persistent health disparities across the nation continue to disproportionately burden minority, vulnerable, and other at-risk subpopulation groups. Poor health outcomes for African Americans, Hispanic Americans, American Indians and Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders are apparent when comparing their health indicators against those of the rest of the U.S. population. These populations experience higher rates of illness and death from health conditions such as heart disease, stroke, specific cancers, diabetes, HIV/AIDS, asthma, hepatitis B, and overweight and obesity. OMH's primary responsibility is to improve health and health care outcomes for racial and ethnic minority communities by developing or advancing policies, programs, and practices that address health, social, economic, environmental and other factors that impact health.

Recognizing that state and territorial minority health entities play a pivotal role in promoting health equity and reducing the physical and financial costs of health disparities, OMH partnered with these entities to obtain local, contextualized data that ultimately will help inform OMH policy and program investments. The diversity of state and territorial priorities and contexts are represented by the profiles. From the onset, OMH recognized the need to tailor its data collection approach to allow each state to identify its unique challenges, specific racial and ethnic health disparities, financial resources, and organizational infrastructure. Reports from the states, not surprisingly, varied considerably in their approaches to reduce health disparities and promote health equity.

## Goals and Structure of the Health Disparities Report

The guiding framework for this report consists of three primary goals:

1) Present summary snapshots of infrastructure around health disparities reduction, health equity promotion, and minority health initiatives for each state and territory.
2) Incorporate quantitative data that assess demographics and prevalence for selected health conditions and mortality within each state and territory.
3) Describe available resources, existing partnerships, activities, and funding dedicated to promoting health equity.

While policymakers have access to quantitative data sets that provide a configurative snapshot of an existing health and socio-demographic landscape, they often lack insight about critical situational factors that contextualize the data into a cogent and robust picture. OMH contracted with Westat to help bridge this contextual gap through the development of individual profiles on states and territories that synthesize existing data with the perspective of each minority health entity, thereby creating a more nuanced representation of the sub-federal health equity landscape.

This report is intended to provide a picture of each state and territory's infrastructure around health equity, disparities elimination, and minority health. It explores, in detail, the specific activities and partnerships that establish the health equity landscape in each state and territory—including available resources, existing partnerships, activities, and funding dedicated to promoting health equity. This information is synthesized into a narrative description, based upon interviews with minority health entities in each state and territory. Each profile includes standardized quantitative data elements that assess demographics and disease/condition prevalence within each state and territory.

The first part of the ***State and Territorial Efforts to Reduce Health Disparities Report*** provides an overview of the report and its purpose. It also explores the role

16 National Academies of Sciences, Engineering, and Medicine, Ibid.

17 Graham H. Social determinants and their unequal distribution: Clarifying policy understandings. Milbank Q. 2004;82(1):101-124.

18 Institute of Medicine. 2003. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington, DC: The National Academies Press. Available at: https://doi.org/10.17226/10260.

and significance of OMH's partnership with states and territories, describes the role of key stakeholders in developing the data collection instrument and the methods used for data collection and reporting.

The second section of the report presents profiles of each state and territory, which reflect a brief snapshot of findings for each state and territory. Each profile includes descriptions of the minority health entity (i.e., organizational structure and distribution of responsibility), program goals and activities (i.e., planning activities, documents, and health equity priorities and strategies), partnerships, staffing, and funding details. Each profile also includes standardized quantitative data to assess demographics and condition prevalence within each state and territory, enabling common reference points across all states and territories that help with benchmarking efforts.

## Methodology

Recognizing that state and territorial minority health entities are critical partners to federal policymakers working towards a goal of zero health disparities, OMH and state/territorial minority health entities are dedicated to the use of partnerships to effectively and efficiently utilize limited resources and create systems change through the inclusion of all stakeholders to ultimately eliminate health disparities.

Earlier Association of State and Territorial Health Officials (ASTHO) surveys of state offices of minority health relied upon static instruments completed on paper or via the Internet. As the need for evolving landscape necessitated collection of more nuanced information grew, OMH transitioned to a more robust and "high-touch" data collection mechanism for this report and contracted with Westat and OMH to create a semi-structured telephone interview protocol that allowed researchers to delve into details and assess insights about the culture and infrastructure around health equity within each state or territory.

OMH and Westat developed the interview protocol in close consultation with a technical advisory panel (TEP) established by OMH to provide input both into the report elements generally and on the survey collection protocol in particular. Comprised of key stakeholders, thought leaders, subject matter experts, and OMH partners (see Acknowledgments section for the full roster), the TEP met in December 2015, and its recommendations addressing appropriate categories, question sequencing, and specific language were incorporated into the final protocol. The major protocol sections include: organizational structure of each minority health entity, programmatic goals and activities, partnerships to advance health equity, existing human resources/staffing within the minority health entity, and dedicated funding.

The protocol was then submitted to the U.S. Office of Management and Budget (OMB) and Westat's Institutional Review Board (IRB). Upon obtaining both OMB[19] and IRB[20] approval to proceed, the team used the protocol to conduct seven pilot interviews with leaders within those state and territorial minority health entities. Westat synthesized the information gathered from each interview into a draft profile, submitted the seven pilot profile drafts for OMH's review, and revised per OMH feedback. Using this information, Westat also finalized the profile structure and created a final profile template.

During the pilot window, Westat also worked closely with OMH to identify and confirm the specific quantitative data points that appear within the profile's data table. OMH confirmed both the variables and the specific data sources for each, and Westat amassed said data for each of the 56 profiles. Westat team members populated this information into a data table for each state and territory that would appear on the final page of the profile. Data sources for the tables include the following:

- American Community Survey Public Use Microdata, 2016 (for total state population)
- Health Resources and Services Administration's Designated Health Professional Shortage Area Statistics, 2018 (for primary care health professional shortage area population)
- Centers for Disease Control and Prevention's (CDC) Wonder Online Database for vital statistics (infant mortality rate is the number of deaths per 1,000 births in 2015; age-adjusted mortality rate is the number of deaths per 100,000 population in 2016)

19 OMB approval issued December 9, 2015 under OMB control number 0990-0441, expiration date: December 31, 2018.
20 Westat IRB approval issued April 21, 2017.

- CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015 (for HIV prevalence rates)
- Behavioral Risk Factor Surveillance System, 2016 (for prevalence of selected chronic diseases and preventive services).

The Westat team then divided the 56 states and territories included in this report into sequential waves to ensure that the interviewers could focus upon one state or territory at a time, enabling them to compose language for the profile immediately upon completing each interview. This phased approach minimized the time between the initial interview and the final profile submission. The full team of Westat interviewers then began the data collection phase of the project by conducting semi-structured telephone interviews with contacts, provided by the Health Officials, at each state and territorial health entity. Interviewers drafted profile language and, as needed, coordinated subsequent contact with interviewees to obtain additional information clarifying questions raised during Westat's internal fact checking and review process. Westat's project leadership then revised the profiles and submitted them, in batches, to OMH. After Westat addressed any subsequent OMH questions or edits, the profile was shared with each state or territorial minority health entity for review. This final step provided an opportunity for each state or territory to clarify any inaccuracies or include pertinent updates to the narrative. OMH and Westat addressed any comments raised during the state/territory review process, and Westat populated the final text into the template for each profile and produced the final report. It is important to note that each profile is intended to be a snapshot of the state/territory at the time of the interview with Westat team. Special notes are provided in the profiles of those jurisdictions that have undergone significant organizational changes since the survey interview was conducted.

## Summary of Findings

In assessing the aggregated set of 56 state and territorial profiles, several themes emerge. This section provides a summary of findings from the aggregated set of profiles.

### Minority health overview

An analysis of data included in the minority health overview sections indicate that, for example, 23 states and territories have in place a strategic plan specifically addressing minority health or health equity. Nearly all of these plans are publicly available. Among those that do not, 22 include health disparities or health equity goals within their state department of health strategic planning processes. Of the 45 states and territories with either a stand-alone or an integrated strategic plan addressing health equity issues, 12 updated the plan in or after 2016.

### Organizational structure and staffing

Minority health entities operate within the state or territorial departments of health. In most cases, an agency within the department is explicitly identified as the minority health entity, although some profiles indicate that the responsibilities of such an entity are spread across the entire department.

Across all 56 states and territories, 216 full-time staff members work exclusively on health equity and minority health issues, with an average of 5 staff for each state or territory with any full-time staff (although 10 states/territories reported having only 1 full-time staff member assigned to these issues). Another 11 full-time individuals (from Texas and Louisiana) work at least 50 percent on health equity, disparities, or minority health topics. Six states and territories report that at least some of the department-level staff work on minority health and seven identified vacancies within its minority health entity at the time of the interview.

An official advisory body helps 33 states and territories set its priorities. In some cases, minority health-related priorities are also determined through other mechanisms, such as executive and legislative mandates (e.g., Florida).

### Program goals and activities

Among the most common program goals and activities are measure development and data collection/analysis (California). Common programs or activities are highlighted in Table 1, below.

**Table 1. Examples of State and Territorial Programs and Activities**

| Type of State Program or Activity | Number of States and/or Territories |
|---|---|
| "State Partnership Initiative to Address Health Disparities" | 33 |
| Cancer Screening | 20 |
| Mental Health and/or Substance Abuse | 17 |
| Health in All Policies | 8 |
| HIV Prevention or Treatment in Minority Communities | 9 |
| Oral Health Issues | 5 |
| Eliminating the Health Disparities Initiative | 2 |
| Suicide Prevention | 2 |
| Community-Based Participatory Research | 2 |

Other activities include Medicaid expansion efforts, immunization programs, chronic disease management efforts targeting particular health issues (e.g., Florida's diabetes self-management program for African and Hispanic communities). Some states and territories leverage multimedia educational efforts as well (e.g., Kansas's video on social determinants of health).

Many states and territories address disparity reduction and equity among particular populations, such as children (18 states/territories). Of those efforts, common themes are prenatal and infant care (Alaska, Arkansas, Guam, Puerto Rico), dental screenings (Massachusetts and Missouri), and efforts targeting specific communities (e.g., Minnesota's work on preventing violence against Asian children and women). Other population-based initiatives address refugee health screening and services (13 states) or support the homeless (Maryland and Puerto Rico). Some states focus efforts on particularly vulnerable populations, like young children among the refugee community through "Friends of Refugees Mommy and Me" programming (Georgia) and efforts to reduce disparities among homeless youth (Maryland).

### Partnerships

All 56 profiles reflect partnerships to improve minority health, health disparities, and health equity between public and nonpublic organizations (e.g., between the department of health and either universities, community-based organizations, or disease- or condition-specific nonprofit organizations) and/or collaborations between various public agencies (e.g., departments of health, education, justice, environment). Relative to the policy arena, several profiles highlight key partnerships involving state legislatures (8). States and territories partner frequently with universities (34), often to provide volunteer staffing for minority health entity offices or initiatives. In 11 states, minority health entities work together with faith-based organizations. In states or territories with a predominant minority population, partnerships often develop with agencies or organizations focused upon those specific groups. For example, given that 229 federally-recognized tribal entities call Alaska home, its health department meets biannually with the Alaska Native Health Board to discuss policy issues, set common priorities, and identify opportunities for collaboration. Nearly all states and territories (49) report having some contracts, memoranda of understanding, or similar formal structures (e.g., interagency agreements).

### Funding

Sources of funding for minority health entities vary. Most receive funds authorized by the legislature of the state or territory itself and some also receive federal dollars (e.g., from OMH, the Centers for Medicare and Medicaid Services, or CDC). Some also receive support from foundations (e.g., Kaiser Family Foundation, California Healthcare Foundation). For the 47 state and territorial profiles for which we have funding data, the federal government is the largest funding source for 16 (34%), while the state/territory itself is the largest funding source for 31 (66%).

## Conclusions

Despite having limited resources, this study found that states and territories are pursuing a wide array of activities to achieve health equity by tailoring efforts to their individual contexts (e.g., resource availability, demographics, and health disparity challenges). Overall, findings reflect rich programs and activities within most states and territories, examples of which include:

- The availability of strategic plans, some of which are in the public domain
- Established goals and objectives that address health disparities and/or health equity
- A separate minority health entity or minority health responsibilities are integrated within a state department
- An official advisory body
- Population-based disparity reduction and equity initiatives
- A vast array of diverse partnerships
- Funding authorized by state legislatures.

The breadth of initiatives speaks to the range of existing health disparities and the commitment of stakeholders to innovatively join efforts to improve minority health. As such, this research illustrates the profound effect that public-private partnerships can have on improving health and health care for all.

**Legislative activity.** An important partner for several states has been its own legislative body. In 2016, the National Conference of State Legislatures reports that 8 states enacted 11 measures addressing health disparities, equity, and minority health issues. For example, California and Hawaii adopted resolutions urging their state departments of health to endorse the "Screen at 23" campaign to screen all adult Asian Americans with a body mass index of 23 or more for type 2 diabetes as an effort to eliminate diabetes disparities. Minnesota, meanwhile, created a program that establishes a "good food access program" to increase the availability of and access to affordable, nutritious, and culturally appropriate food, including fresh fruits and vegetables, for underserved communities. Additionally, three measures remain pending in the New Jersey legislature, including one that establishes a commission on "Disparity in Treatment of Persons with Disabilities in Underrepresented Communities."

**Laying a future research agenda.** This report lays critical groundwork to monitor progress by states and territories in their efforts to achieve health equity. These 56 profiles establish a benchmark against which we can assess future efforts, tracking progress as well as challenges and strategies to overcome them. Moving forward, biannual updates that include dashboards and additional indicators would provide an even more robust picture of each state's and territory's minority health landscape.

### Recommendations

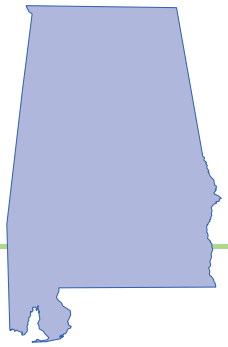
Based on the state and territorial profiles, Westat has identified several key opportunities to expand upon the investment and foundation created by this contract. For example, one limitation of this work is that its focus is the individual state or territory without consideration of the broader regional efforts and implications of minority health initiatives. For this reason, expanded qualitative data collection efforts (i.e., augmenting the individual state/territorial surveys with regional focus groups of minority health entity staff) would provide a deeper vision of how the states and territories work together to address area-wide health equity issues.

Other opportunities involve delving deeper into the data set developed for this report. Westat has developed a database of the 56 profiles, which can be leveraged to produce research briefs on such topics as statewide disparity-reducing policies, successful condition-specific efforts, replicable partnerships, and funding characteristics. Westat recommends, for example, that the OMH produce a series of **dashboards and briefs on particular health conditions** targeted by state/territory-identified initiatives for which disparities are significant and/or growing. Examples might include state/territory efforts to reduce disparities in opioid use, infant mortality, diabetes, or HIV.

Researchers could also mine the database Westat amassed through this project to conduct a partnership analysis and inventory, documenting the types of organizations that states and territories have partnered with, how those partnerships have evolved over time to advance health equity goals, and what options other states or territories may have to create similar partnerships within their own borders. This analysis could highlight the complementary roles academic partners, state agencies outside of the minority health entity, and community-based organizations play in the health equity landscape—providing insights for states and territories interested in expanding existing partnerships.

Additionally, researchers could expand upon the data collected for this report to explore in more detail how states and territories **operationalize and measure success of policy efforts** (e.g., Medicaid expansions, Health in All Policies, or the "Eliminating Health Disparities Initiative"). Such an analysis could identify successful strategies states and territories could employ to further advance health equity. Other analyses could explore outcome variables such as **high versus low funding streams**, documenting activities of states and territories that have successfully secured foundation or federal dollars for disparity reduction that may be replicated.

# Alabama



## Introduction to Alabama's Health Equity Activities

Alabama had an estimated 2016 population of 4,863,000. Blacks/African Americans are the largest racial-ethnic minority population (27 percent), followed by Hispanics/Latinos (4 percent) and Asian Americans and NHOPI (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 3 percent of the population.[1] Approximately 1,919,000 Alabama residents live within a primary care health professional shortage area.[2]

Minority health activities in the Alabama Department of Public Health (ADPH) are housed within the Nutrition and Physical Activity (NPA) Division of the Bureau of Health Promotion and Chronic Disease. Between 1991 and 2013, the ADPH included a standalone Office of Minority Health. That entity was discontinued in 2013; minority health activities resumed in 2015, when the ADPH received funding through a State Partnership Initiative to Address Health Disparities (SPI) grant from the U.S. Office of Minority Health. Minority health work under the 5-year grant functions as a program within the NPA Division. The goal of the SPI grant project is to "implement strategies that will aid in positive behavior change to address risk factors that can be controlled through behavior." Grant activities focus on nutrition, physical activity, and access to health care services among minority populations in four geographic "hot spots" around the state.[3]

### Alabama Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | The former OMH was discontinued in 2013 and presently no standalone entity exists. The Nutrition and Physical Activity Division coordinates minority health activities. |
| Strategic plan in place to address minority health or health equity | No strategic plan has been developed since minority health activities resumed in 2015. |
| Date strategic plan was last updated | N/A |
| Assessment plan in place to measure progress toward reducing health disparities | Not yet developed. |
| Key strategies used to achieve health equity | • Promoting physical activity<br>• Promoting healthy vending machines<br>• Improving access to health care services<br>• Expanding Scale Back Alabama, a statewide weight loss program |

## Organizational Structure

Minority health activities stem from the SPI grant awarded in August 2015, which the NPA Division implements and coordinates. Additionally, the Governor's Office of Minority Affairs was established in March 2016 by executive order. The former minority health program director participates in its work, advising the governor on minority health issues. That position was vacant at the time of the data collection for this report.

The NPA Division has three staff members and one vacant program director position; none are dedicated full time to minority health and health equity initiatives. These include one program nutritionist (0.5 FTE), one wellness specialist and nutritionist (0.3 FTE), and the NPA Division Director (0.1 FTE). Community volunteers and University of Alabama interns help with some local

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 U.S. Department of Health and Human Services Office of Minority Health. Grant Program: State Partnership Initiative to Address Health Disparities

programs. Additionally, each grant hot spot has a health coalition whose members help with recruitment and outreach. NPA's program director position, which dedicates 50 percent time to minority health initiatives, is funded through the SPI grant. Other than filling the vacancy, no staffing changes are anticipated.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | Minority health activities are housed in the Nutrition and Physical Activity Division within the Alabama Department of Public Health, Bureau of Health Promotion and Chronic Disease |
| SMHE staffing (full-time equivalents) | 4 |
| Advisory committee or panel | None |

## Program Goals and Activities

No strategic plan has been developed since minority health activities resumed with SPI grant funding in 2015. Minority health work in the NPA Division focuses largely on the grant objectives. The ADPH also integrates minority health work into other funding sources and grant activity plans throughout the department. At the time of data collection, there were no plans to develop a strategic plan specific to minority health, health disparities, or health equity. However, the SPI grant project identifies several intermediate and long-term performance measures for monitoring progress during the grant period, all related to nutrition, obesity levels, lifestyle changes, and access to health care.[3] Efforts to plan and conduct evaluations under the SPI grant have not been finalized.

ADPH minority health activities stem primarily from the SPI grant. The NPA Division coordinates and implements grant activities, and works with grant partners to set minority health priorities based on population need, focusing on areas with larger minority populations and higher obesity rates. Outside of the SPI grant, the NPA Division also participates in events with the University of Alabama and other entities to increase awareness of health disparities and health equity issues.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Alabama Department of Public Health | ADPH |
| Nutrition and Physical Activity Division | NPA Division |
| Alabama State Partnership Initiative to Assess Health Disparities grant | SPI grant |

The SPI grant designates four hot spots that have high obesity rates, low levels of physical activity, and limited access to health care. These areas have significant minority populations and include the cities of Demopolis, Greensboro, Livingston, and Marion. As part of SPI grant activities, the NPA Division strives to do the following in each of the hot spots (described in further detail below):

- Increase physical activity opportunities.
- Increase healthy nutrition options.
- Increase access to health care services.
- Expand the reach of the Scale Back Alabama weight loss program.

Seeking to increase the variety of physical activity opportunities available in the hot spot areas, the NPA Division determined that many community members were willing to start Zumba classes. As a result, the SPI grant is funding Zumba classes in the hot spots, as well as training opportunities to become Zumba instructors in those communities.

The NPA Division also is working to get vending entities in the hot spots to offer healthier vending machine options in settings such as schools and hospitals. The NPA Division is especially seeking to increase access to healthy vending machine options in Tuscaloosa, which has a large Hispanic population.

The NPA Division also coordinates several SPI grant activities that aim to increase access to health care services within the hot spot areas. Each hot spot has a resource person who facilitates application for health insurance and promotes awareness of health facilities and services. A resource guide and mobile phone app were developed to assist in sharing such information. Seeking to expand the health care workforce, the NPA Division partners with the West Central Alabama Area

Health Education Center to encourage individuals to consider careers in health care within their local communities.

Finally, as part of the SPI grant, the statewide weight loss program, Scale Back Alabama, has created sites in each hot spot area where citizens can participate in the program, receive blood pressure monitoring and other health care services, and learn about healthier eating and exercise.

### Partnerships

| | |
|---|---|
| Primary collaborators | • West Central Alabama Area Health Education Center<br>• Alabama Cooperative Extension Services<br>• University of Alabama<br>• County health departments<br>• State Obesity Task Force |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

The NPA Division partners with governmental and nongovernmental organizations as part of the SPI grant to work toward eliminating health disparities and advancing health equity in Alabama. For example, the West Central Alabama Area Health Education Center serves several low-income counties with large minority populations and has a formal contract to assist with grant activities. The center focuses on increasing physical activity opportunities, promoting healthier food options, and increasing access to health care in the hot spots.

The Alabama Cooperative Extension System assists with grant hot spot initiatives through an informal partnership. Through its strong connections within communities, the extension system works to implement Scale Back Alabama and promote healthier vending machine options.

The University of Alabama is located near one of the hot spots with a large Hispanic population. Through an informal partnership, the university allows the NPA Division to use campus facilities for meetings with health educators in the Hispanic community who assist with initiatives to increase physical activity, nutritious food choices, and access to health care. The NPA Division provides campus presentations to increase student awareness of health disparities and health equity issues.

The NPA Division partners with county health departments in the SPI grant hot spots to connect the program to community populations. The departments provide space for grant activities such as community forums and health meetings, and help disseminate information about Scale Back Alabama and physical activity opportunities. The formal contracts with county health departments are at the state level through the ADPH.

Finally, the NPA Division partners with the State Obesity Task Force by sharing resources that are disseminated in the hot spots. Several NPA Division staff are members of the task force, and the NPA Division and the task force share information on a regular basis.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $200,000 (awarded annually beginning in August 2015) |
| Annual budget (FY 2015) of SMHE from state/territorial government | $0 |
| Largest funding source | Federal government |
| Anticipated changes to budget | None |

The total FY 2015 funding for the minority health program was $200,000. The $200,000 is awarded annually as part of the 5-year U.S. Office of Minority Health State Partnership Initiative to Address Health Disparities (SPI) grant. The ADPH contracted with the West Central Alabama Area Health Education Center in 2015, awarding the center a $30,000 subgrant to help carry out SPI grant strategies.

The minority health program did not anticipate any funding changes.

# Alabama

## Alabama State Data

| Total Population[a]: 4,863,300 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 4.1 | 95.9 | 68.1 | 26.9 | 0.5 | 1.3 | 3.2 | 100.0 | NA |
| Percent of population medically uninsured[a] | 27.2 | 9.0 | 8.2 | 12.2 | 17.3 | 11.9 | 18.9 | 9.7 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 8.6 | 5.7 | 14.3 | SP | SP | NC | 8.3 | 5.9 |
| Age-adjusted mortality rate[b] | 282.7 | 931 | 907.0 | 988.5 | 278.5 | 421.9 | NC | 920.4 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 11.4 | 15.0 | 14.4 | 16.7 | 19.3 | 10.3 | 14.1 | 15.0 | 13.6 |
| Percent with diabetes[c] | 7.5 | 14.9 | 13.9 | 17.1 | 17.4 | 2.9 | 11.6 | 14.6 | 10.8 |
| Percent with heart disease[c] | 2.2 | 6.3 | 7.2 | 3.7 | 9.2 | 0.0 | 2.1 | 6.2 | 4.3 |
| HIV rate[d] | 267.7 | NC | 123.1 | 747.4 | 21.3 | 58.9** | 1317.5 | 302.4 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 56.2 | 73.9 | 71.5 | 79.8 | 69.1 | 59.3 | 61.3 | 73.2 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 63.7 | 62.6 | 64.2 | 58.1 | 60.6 | 72.9 | 60.0 | 62.6 | 66.5 |
| Percent received flu vaccine[c] | 31.6 | 36.9 | 39.4 | 31.7 | 30.0 | 32.1 | 24.1 | 36.9 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

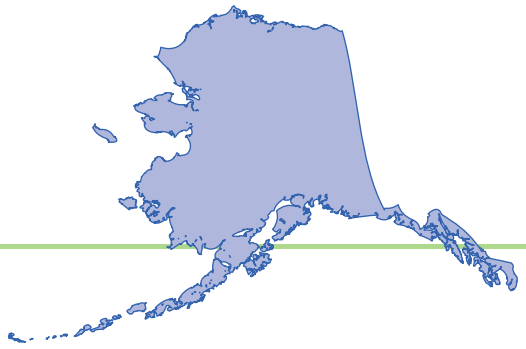
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 58.9 per 100,000 population (32 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 270.1 per 100,000 population (5 cases).

# Alaska



## Introduction to Alaska's Health Equity Activities

Alaska had an estimated 2016 population of 742,000. American Indians/Alaska Natives (16 percent) are the largest racial-ethnic minority population, followed by Asian Americans and NHOPI (7 percent), Hispanics/Latinos (7 percent), and Blacks/African Americans (3 percent). Persons self-identifying as multiracial or "other race" comprise 9 percent of the population.[1] Approximately 117,000 Alaska residents live within a primary care health professional shortage area.[2]

While minority health and health equity are not the exclusive focus of any one state entity, the Division of Public Health (DPH) within Alaska's Department of Health and Social Services (DHSS) addresses health disparities and the health of minority populations. Indeed, among the DPH's core values is health equity, which it defines as "ensuring all Alaskans have full and equal access to opportunities to lead healthy lives." Disparity reduction also falls into the DPH's broader mission, which is to "protect and promote the health of Alaskans."[3]

### Alaska Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | N/A |
| Strategic plan in place to address minority health or health equity | Although there is no explicit strategic plan specifically addressing minority health or health equity, the *Alaska Division of Public Health Strategic Plan, 2016 – 2020* and the State Health Improvement Plan, *Healthy Alaskans 2020*, both address these issues. |
| Date strategic plan was last updated | 2016 |
| Assessment plan in place to measure progress toward reducing health disparities | The State Health Improvement Plan, *Healthy Alaskans 2020*, includes 25 leading health indicators for measuring progress toward health objectives. |
| Key strategies used to achieve health equity | • A key strategy from the *Alaska Division of Public Health Strategic Plan 2016 – 2020* is to "collaborate to achieve health equity for Alaskans."<br>• The Alaska Division of Public Health is working to reform and expand Medicaid. |

## Organizational Structure

The DPH operates within the DHSS, Alaska's primary public health entity, and collaborates with partners throughout Alaska. Its director, who is also the DPH's chief medical officer, has responsibility for addressing minority health, health disparities, and health equity as part of the DPH's mission. Likewise, all DPH staff work to fulfill DPH's goals, including ensuring health equity, and DPH activities reflect a commitment to issues affecting minority health, health disparities, and health equity. That said, no DPH staff work full time exclusively on minority health, health disparities, or health equity initiatives.

No advisory committee or panel has responsibility for advising the DPH on minority health, health disparities, and health equity. However, various groups informally advise the DPH on activities, such as a tribal Medicaid advisory group and a resiliency working group. Multiple working groups contributed to developing the state health improvement plan, *Healthy Alaskans 2020*. Both the Alaska Division of Public Health Strategic Plan, 2016-2020 and the State Health Improvement Plan, *Healthy Alaskans 2020*, were last updated in 2016.

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.
3 Alaska Division of Public Health. Alaska Division of Public Health Strategic Plan 2016 – 2020.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | There is no specific SMHE. The Alaska Division of Public Health within the Department of Social Services addresses minority health, health disparities, and health equity. |
| SMHE staffing (full-time equivalents) | 0 |
| Advisory committee or panel | None |

## Program Goals and Activities

The DPH developed the *Alaska Division of Public Health Strategic Plan 2016 – 2020 ("Strategic Plan")*, a publicly available document that lists the DPH's mission, vision, value, and goals. It articulates a list of strategies, beginning with a call for the DPH to: "[c]ollaborate to achieve health equity for Alaskans." The DPH also worked with the DHSS and other partners to develop the state health improvement plan, *Healthy Alaskans 2020*. In selecting objectives for *Healthy Alaskans 2020*, one criterion was that "[o]bjectives should address [health] equity and differences in health status and services across different population sub-groups, including race, socioeconomic, age, gender, disability status, and geographic groups."[4] Other divisions within the DHSS also implement activities relevant to minority health, health disparities, and health equity. Other DPH initiatives that do not explicitly address health equity may have significant implications for minority health. For example, given that 35.4 percent of the state's American Indian/Alaska Native population is uninsured,[5] the recent Medicaid expansion—which expands eligibility and adds behavioral health to the list of covered services—helps to ameliorate an important disparity. Relatedly, the DHSS's Tribal Health Program provides technical assistance to tribal health care providers during expansion and/or development of Medicaid programs.[6]

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Alaska Department of Health and Social Services | DHSS |
| Division of Public Health | DPH |

### Partnerships

| | |
|---|---|
| Primary collaborators | • Alaska Native Tribal Health Consortium<br>• Alaska Native Health Board<br>• Anchorage Faith and Action Congregations Together<br>• Southcentral FoundationContracts or memoranda of understanding with any partners |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships (e.g., the Alaska Native Tribal Health Consortium). |

The DPH and the DHSS collaborate with many partners as part of minority health, health disparities, and health equity activities. Because Alaska has 229 federally recognized tribal entities,[7] the DPH and the DHSS partner with several organizations addressing American Indian/Alaska Native health issues throughout the state. For example, the DPH meets biannually with the Alaska Native Health Board on broader policy decisions, policy implementation, priority setting, and to identify opportunities for collaboration.

Through multiple memoranda of understanding, the DPH and the DHSS also work with the Alaska Native Tribal Health Consortium and regional tribal corporations. Specifically, the DPH and the Consortium collaborated on Healthy Alaskans 2020, while the Consortium and the DHSS jointly reviewed health improvement efforts from previous decades and identified an initial 71 possible health indicators that are useful today. Consultation with subject matter experts and public input from two online surveys led to the current list of 25 leading health indicators and associated targets.[8]

4 Alaska Department of Health and Social Services and Alaska Native Tribal Health Consortium. "Healthy Alaskans 2020 Health Assessment: Understanding the Health of Alaskans."

5 American Community Survey Public Use Microdata, 2014.

6 Alaska Department of Health and Social Services, Office of the Commissioner. "Tribal Health Program: A Commitment to Improving the Health Status of Alaska Native People." Last updated on the DHSS website in 2015.

7 Bureau of Indian Affairs, Interior. Indian Entities Recognized and Eligible To Receive Services From the United States Bureau of Indian Affairs. (81 FR 2019). Publication Date: January 29, 2016.

8 Alaska Department of Health and Social Services and Alaska Native Tribal Health Consortium. HA 2020 Process.

Divisions within the DPH also partner with various tribal groups to address minority health, eliminate health disparities, and achieve health equity. For example, the DPH Section of Emergency Programs contracts with tribal health organizations to distribute the Centers for Disease Control and Prevention's strategic national stockpile, which is the nation's largest pharmaceutical and medical supplies for use in severe public health emergencies when local supplies run out.[9] A statewide immunization program, operated by the DPH Section of Epidemiology, also works closely with tribal health organizations. In 2014, their combined efforts resulted in childhood vaccination rates for 19–35 month-old children in Alaska Native populations (i.e., 76.2 percent) that exceeded rates in non-native children in that same age cohort (i.e., 67.3 percent).[10] Similarly, the DPH Section of Public Health Nursing staffs 22 public health centers, many of which operate under tribal organizations. The DPH Section of Women's, Children's and Family Health, meanwhile, works with the Southcentral Foundation—an Alaska Native-owned, nonprofit, regional health care organization—to provide prenatal care support and prevent adverse childhood experiences. Additionally, a preliminary and informal partnership between the DPH and Anchorage Faith and Action Congregations Together—an organization of churches and faith communities with predominantly Hispanic populations—has emerged to improve access to drug rehabilitation facilities.

## Funding

| | |
|---|---|
| Annualized budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | Unavailable |
| Annual budget (FY 2015) of SMHE from state/territorial government | Unavailable |
| Largest funding source | Unavailable |
| Anticipated changes to budget | Possible |

The DPH and the DHSS funding come from multiple sources, with minority health, health disparities, and health equity activities integrated as part of larger initiatives to address the health of Alaskans. The DPH and the DHSS provide funding to many tribal health organizations through grants that are sometimes complex. For instance, one DPH grant had more than 20 recipients. Following recent state budget decreases, funding is expected to decrease further.

9 Centers for Disease Control and Prevention. Office of Public Health Preparedness and Response. Strategic National Stockpile. Last updated on the CDC website on March 2, 2017.

10 Centers for Disease Control and Prevention. Office of Public Health Preparedness and Response. Strategic National Stockpile. Last updated on the CDC website on March 2, 2017.

# Alaska

## Alaska State Data

| Total Population[a]: 4,863,300 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 6.9 | 93.1 | 64.8 | 3.0 | 15.9 | 7.2 | 9.2 | 100.0 | NA |
| Percent of population medically uninsured[a] | 13.8 | 14.4 | 10.4 | 9.1 | 28.4 | 18.8 | 16.9 | 14.4 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 7.3 | 4.8 | SP | 14.5 | SP | NC | 6.9 | 5.9 |
| Age-adjusted mortality rate[b] | 393.7 | 756.6 | 682.2 | 578.1 | 1226.6 | 525.7 | NC | 745.6 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 12.4 | 14.2 | 13.8 | 9.7 | 16.9 | 14.8 | 22.8 | 14.6 | 13.6 |
| Percent with diabetes[c] | 5.7 | 7.3 | 7.6 | 14.6 | 8.4 | 2.5 | 5.3 | 7.6 | 10.8 |
| Percent with heart disease[c] | 2.5 | 2.8 | 3.7 | 0.0 | 1.8 | 0.3 | 0.4 | 2.8 | 4.3 |
| HIV rate[d] | 167.7 | NC | 76.0 | 430.2 | 190.6 | 50.9** | 115.9 | 109.3 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 46.0 | 60.8 | 61.0 | 85.3 | 54.7 | 56.4 | 45.6 | 60.2 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 69.3 | 65.5 | 66.2 | 76.1 | 58.8 | 70.7 | 63.4 | 65.8 | 66.5 |
| Percent received flu vaccine[c] | 11.5 | 35.5 | 34.0 | 57.9 | 36.0 | 38.1 | 18.6 | 34.9 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

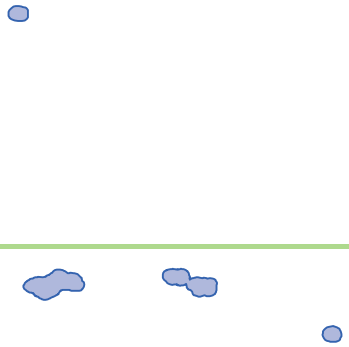
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 50.9 per 100,000 population (19 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 44.7 per 100,000 population (3 cases).

# American Samoa



## Introduction to American Samoa's Health Equity Activities

American Samoa is an unincorporated U.S. territory, with an estimated 2010 population of 56,000. Pacific Islanders are the largest racial-ethnic population (93 percent), followed by Asians (4 percent). Persons self-identifying as multiracial or "other race" comprise 4 percent of the population.[1]

Because most American Samoans belong to a racial minority group, the American Samoa Department of Health (ASDOH) embeds minority health and health equity activities throughout its work. As such, it does not have a separate office solely dedicated to minority health, health disparities, or health equity issues. The ASDOH's primary responsibilities are to address the health needs of American Samoans and to lead advocacy efforts on their behalf. Initiatives and activities to address health disparities often involve both the ASDOH and the American Samoa Department of Human and Social Services (ASDHSS), requiring close collaboration to coordinate delivery of services. The ASDHSS is responsible for several programs that focus on improving the health and well-being of specific minority subpopulations in American Samoa.

### American Samoa Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | N/A; however, the American Samoa Department of Health (ASDOH) embeds minority health activities throughout its work and has several staff devoted to reducing health disparities. |
| Strategic plan in place to address minority health or health equity | No strategic plan with a specific focus on minority health or health equity is available. |
| Date strategic plan was last updated | N/A |
| Assessment plan in place to measure progress toward reducing health disparities | No formal assessment plan is in place; however, a home visiting program helps the ASDOH measure and track health status in American Samoan villages. |
| Key strategies used to achieve health equity | • Implementing tuberculosis initiative<br>• Improving access to quality health care<br>• Controlling communicable disease |

## Organizational Structure

The ASDOH is responsible for providing clinical health care services as well as public health services. The Department of Public Health within the ASDOH leads initiatives to improve the health of the American Samoa population. The ASDHSS, a lateral department to the ASDOH, includes the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), behavioral health services, and other social services programs. While the ASDOH works to advance the health of all American Samoans, the ASDHSS focuses on eliminating disparities on the islands and addressing the needs of non-Pacific Islander minority populations.

The ASDOH has approximately 280 staff members, and they spend at least some portion of their day working to achieve health equity. Three staff members, known as clinical care coordinators/health educators, work specifically to eliminate heath disparities. They focus primarily on the village health assessments and outreach, including providing health education and coordinating the care and services that each village needs.

1 U.S. Census Bureau. 2010 Census Island Areas: 2010 Census Detailed Crosstabulations.

# American Samoa

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/ territorial government | The American Samoa Department of Health is one of several departments housed under the Office of the Governor, along with the American Samoa Department of Human and Social Services. |
| SMHE staffing (full-time equivalents) | The American Samoa Department of Health has approximately 280 employees, many of whom spend some time supporting health initiatives for the population. |
| Advisory committee or panel | None |

## Program Goals and Activities

The ASDOH has an overarching strategic plan to assess and address the health concerns of each American Samoan village individually, taking into account the local culture and traditions of the community. A home visiting program and village-based surveys, along with territorial communicable and non-communicable disease surveillance, are used to evaluate the health concerns and needs of each village. The ASDOH and the ASDHSS use the results of these assessments to develop plans for delivering education and services to meet each village's identified needs.

Most ASDOH strategies are broad and affect the American Samoan majority population, but some target specific minority subpopulations experiencing disparities. For example, a tuberculosis initiative addresses the higher rates of tuberculosis among Filipino and other foreign-born populations in American Samoa. Strategies implemented in American Samoan community health centers also help to address the needs of non-Pacific Islander minority populations.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| American Samoa Department of Health | ASDOH |
| American Samoa Department of Human and Social Services | ASDHSS |

A major focus of the ASDOH has been on improving access to care. Given that all American Samoans are eligible for Medicaid and/or Medicare, health care coverage is universal and standardized for the entire population. The ASDOH and the ASDHSS work collaboratively to expand the health care system's reach by coordinating outreach to communities and ensuring that community health centers have the necessary staffing. Programming and initiatives implemented in the villages largely depend on local needs identified through community assessments and home visits. The goal is to identify people needing care and then link them to appropriate services, locally or beyond. As an example, the ASDOH and the ASDHSS are working to implement courier services for American Samoans in need of care who have transportation barriers.

Communicable disease control is another major strategy to improve the health of all American Samoans. Led by the Office of the Governor, initiatives include partnering with mayors to clean up villages and providing information to villages on how to reduce the spread of communicable diseases. Prevention products (e.g., mosquito nets, repellent) and educational materials are provided free of charge to community members in areas where outbreaks are possible.

# American Samoa

### Partnerships

| | |
|---|---|
| Primary collaborators | • American Samoa Department of Human and Social Services<br>• American Samoa Community College<br>• Lyndon B. Johnson Tropical Medical Center |
| Contracts or memoranda of understanding with any partners | Yes, memoranda of understanding are implemented for some partnerships (e.g., the ASDOH has a general memorandum of understanding with all American Samoan government entities, including the American Samoa Community College and Lyndon B. Johnson Tropical Medical Center). |

The ASDOH partners with the ASDHSS in many of its efforts to eliminate health disparities and improve the health of all American Samoans by improving access to care, conducting village health assessments, and controlling communicable disease transmission. The ASDOH and ASDHSS collaborate with other government agencies, coalitions, and local community-based organizations to carry out the home visiting program in villages, and to support various other activities.

The American Samoa Community College is another key partner for the ASDOH. An entomologist from the college provides consultative services on matters related to vector-borne diseases. The ASDOH also works with the American Samoa Community College to provide hands-on opportunities and mentorship for students. Students support ASDOH activities and initiatives as part of their course practicum, and those who participate in the mentorship program assist the ASDOH with program evaluations.

The ASDOH collaborates with the Lyndon B. Johnson (LBJ) Tropical Medical Center, the only hospital in American Samoa, to increase access to health care professionals and services for communities with limited access. Clinicians in American Samoa are concentrated in Pago Pago, the location of the medical center. When the ASDOH identifies a community that has a health care need that cannot be addressed locally, the ASDOH works with the LBJ Tropical Medical Center to find health care professionals who can travel to the area and provide services to the community. In some cases, the ASDOH will secure a local office or clinic space for visiting health care professionals, or coordinate transportation to shuttle community members to the LBJ Tropical Medical Center for needed care.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $12,000,000 for the American Samoa Department of Health (both clinical and public health) |
| Annual budget (FY 2015) of SMHE from state/territorial government | $1,400,000 for the American Samoa Department of Health |
| Largest funding source | Federal government |
| Anticipated changes to budget | Likely |

The total FY 2015 funding for the ASDOH to support both clinical and public health services for all American Samoans was $12,000,000. Of this annual budget, $1,400,000 was from local sources (e.g., the American Samoa government) and the remainder of the funding was from federal grants. These grants focused on a range of health priorities, including diabetes, tobacco cessation, communicable disease control, and breast and cervical cancer. The largest grant in FY 2015 was from the U.S. Department Health and Human Services, Health Resources and Services Administration for community health centers in American Samoa. The ASDOH expects to receive additional funding specifically to address and prevent the spread of Zika virus in the territory.

# American Samoa

## American Samoa Territory Data

| Total Population[a]: 55,519 | Race | | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|
| | Pacific Islander | | | Asian (includes Filipino) | Multiracial | Other | Territory Total | National Total |
| | Samoan | Tongan | Other PI | | | | | |
| **Population Characteristics** | | | | | | | | |
| Percent of state population[a] | 88.9 | 2.9 | 0.8 | 3.6 | 2.7 | 1.2 | 100.0 | NA |
| Percent of population medically uninsured[a] | 58.0 | 80.1 | 68.9 | 62.1 | 56.5 | 39.0 | 59.2 | 16.3[b] |
| **Health Disparities** | | | | | | | | |
| Vital Statistics | | | | | | | | |
| Infant mortality rate | | | | | | | 10.5[c] | 5.9[d] |
| Age-adjusted mortality rate[d] | | | | | | | 1165.0 | 733.1 |
| Prevalence of Selected Chronic Diseases | | | | | | | | |
| Asthma[e] | | | | | | | NC | 13.6 |
| Diabetes | | | | | | | 47.3[f] | 10.8[e] |
| Heart Disease[e] | | | | | | | NC | 4.3 |
| HIV[g] | | | | | | | 4.7 | 362.3 |
| Preventive Services | | | | | | | | |
| Routine check-up (past 12 months)[e] | | | | | | | NC | 72.2 |
| Oral health visit (past 12 months)[e] | | | | | | | NC | 66.5 |
| Flu Vaccine Received[e] | | | | | | | NC | 38.4 |

**Note:** This jurisdiction's vital statistics, disease prevalence, and preventive services data are not available by race and ethnicity in the data sources compiled for this report.

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: U.S. Census Bureau. 2010 Census Island Areas: 2010 Census Detailed Crosstabulations.

b Source: U.S. Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States: 2010.

c Source: U.S. Department of Interior Office of Insular Affairs. Health Data and Information System U.S. Territories and Freely Associated States: Final Report March 2009.

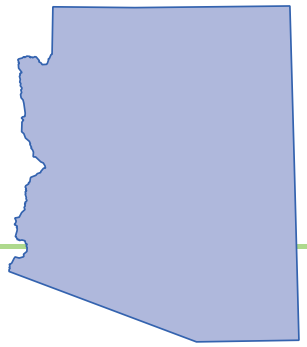
d Source: CDC National Vital Statistics Reports, Deaths: Final Data for 2015.

e Source: Behavioral Risk Factor Surveillance System, 2016.

f Source: World Health Organization. American Samoa NCD Risk Factors Steps Report, 2004 data.

g Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015.

# Arizona



## Introduction to Arizona's Health Equity Activities

Arizona had an estimated 2016 population of 6,931,000. Hispanic/Latino residents are the largest racial-ethnic minority population (31 percent), followed by American Indian/Native Americans (4 percent), African Americans (4 percent), and Asian Americans and NHOPI (3 percent). Persons self-identifying as multiracial or "other race" comprise 12 percent of the population.[1] Approximately 4,771,000 Arizona residents live within a primary care health professional shortage area.[2]

In 2004, the Arizona Department of Health Services' (ADHS) Office of Health Systems Development (OHSD) established the Center for Minority Health (renamed the Arizona Health Disparities Center in September 2006) to address minority health and health equity in the state.

### Arizona Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Arizona Health Disparities Center |
| Strategic plan in place to address minority health or health equity | Arizona Health Equity Stakeholder Strategies |
| Date strategic plan was last updated | 2013 |
| Assessment plan in place to measure progress toward reducing health disparities | Outcome and process measures are included in the strategic plan |
| Key strategies used to achieve health equity | • Implementing Culturally & Linguistically Appropriate Services (CLAS) Standards<br>• Developing health literacy materials for community partners and health systems<br>• Language Access |

## Organizational Structure

Within the ADHS, the Arizona Health Disparities Center (AHDC) is housed within the Health Systems Development Bureau of the Division of Public Health Services. The center serves in a department-wide capacity to address minority health issues.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Office of Health Systems Development | OHSD |
| Health Disparities Center | AHDC |
| Arizona Department of Health Services | ADHS |

The AHDC does not have an advisory committee specifically for minority health or health disparities. However, the center does have a Health Literacy Coalition funded by the U.S. Office of Minority Health. The coalition, which develops materials to address health literacy, includes partners that address health disparities in Arizona. The coalition's members include federally qualified health centers, the Arizona Alliance for Community Health Members, the ADHS Refugee Health Program, Asian Pacific Community in Action, Native Health, and other community partners.

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

Across the ADHS, 10 staff members work full time on minority health, health disparities, and health equity. Four senior staff work full time on health disparities issues: the AHDC Office Chief, the Office of HIV Prevention Office Chief, the Native American Liaison, and the Border Health Liaison. There are also five mid-level, full-time staff, including a State Partnerships Initiative Program Manager, Health in Arizona Policy Initiative Manager, Native American Home Visiting Program Manager, LGBT Liaison–Tobacco Program, and Native American Liaison. As part of its junior staff, the center also employees a full-time epidemiologist and uses student interns from local universities when possible.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | Arizona Department of Health Services, Division of Public Health Services, Health Systems Development Bureau |
| SMHE staffing (full-time equivalents) | 10 |
| Advisory committee or panel | No advisory committee for minority health or health disparities |

## Program Goals and Activities

In 2013, the AHDC published a state Strategic Plan, *Arizona Health Equity Stakeholder Strategies*,[3] to address minority health and health equity. The plan was developed with input from consumers and health and human services providers across the state. Arizona's plan mirrors the format of *National Stakeholder Strategy for Achieving Health Equity*, a report published in 2011 by the U.S. Department of Health and Human Services' Office of Minority Health. Through a strategic planning process, the AHDC will periodically reevaluate and update the *Arizona Health Equity Stakeholder Strategies* plan as needed to ensure that it aligns with the center's overarching direction and goals.

The AHDC's 2013 Strategic Plan lists diabetes, obesity, cancer, substance abuse, heart disease, and teen pregnancy as top health concerns for the state. The plan also outlines five goals for addressing health disparities: awareness; leadership; health system and life experience; cultural and linguistic competence; and data, research, and evaluation. For each goal, the plan identifies strategies, objectives, measures, and recommendations.

With funding from the U.S. Office of Minority Health, the AHDC implements a host of strategies to eliminate health disparities. For example, the AHDC promotes adoption of the National Standards for Culturally and Linguistically Appropriate Services (National CLAS Standards) and launched a National CLAS Standards online training in 2014 in partnership with the Arizona Department of Health Services (ADHS), Bureau of Nutrition and Physical Activity. The purpose of the training is to bring awareness of the National CLAS Standards to people in health care settings. The AHDC has partnered with the Northern Area Health Education Center to provide continuing education credits for participants who complete the online training. The AHDC also created "Implementing CLAS Standards and Improving Cultural Competency and Language Access: A Practical Toolkit."[4] The practical guide provides resources for organizations seeking to implement the National CLAS Standards. Additionally, the AHDC established a Website to explain and disseminate the National CLAS Standards, as well as to promote their implementation; it also includes links to the federal Think Cultural Health Website.

Another important goal of the AHDC is to address the needs of people with limited English proficiency (LEP). HRC aims to improve access for people with LEP to interpretive services, resources, and information through research, strategic alliances, and resource development by providing health literacy materials at no cost to community partners, health systems, providers, and patients. Examples of available materials include:

- *I Speak* cards to assist people with limited English proficiency to communicate which language they speak when interacting with health care providers and others;
- *Know Your Language Access Rights* fact sheets that help people with limited English proficiency to understand their right to request a qualified medical inter-

3 The Arizona Health Equity Stakeholder Strategies: January 2013 report is available on the Arizona Department of Health website. Last accessed: 1/13/2018.

4 "Implementing CLAS Standards and Improving Cultural Competency and Language Access: A Practical Toolkit." Published by the Arizona Health Disparities Center, produced by the Arizona Health Alliance for Language Access Rights, December 2014. Available on the Arizona Department of Health website. Last accessed: 1/13/2018.

preter at no cost to them, and to provide information about available resources in the community; and

- Laminated handouts with flags from countries/regions that people with limited English proficiency can use to show their country of origin when interacting with health care providers and others.

In 2012, the AHDC formed the Arizona Health Alliance for Language Access Rights with the goal of "creating and sustaining a welcoming environment that embraces Language Access Services (LAS) in Arizona." The alliance includes stakeholders from key government, community, and local organizations.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Arizona county health departments<br>• Association of Community Health Centers<br>• Center for Rural Health at the University of Arizona<br>• Local universities<br>• Health in Arizona Policy Initiative<br>• Organizations that represent racial and ethnic groups<br>• Department of Health Services, Office of Border Health |
| Contracts or memoranda of understanding with any partners | Yes, contracts are implemented for some partnerships (e.g., with county health departments). |

At the state and local levels, the AHDC collaborates with governmental and nongovernmental agencies to advance its efforts to achieve health equity. It works closely with Arizona county health departments, which serve as "boots on the ground," and are responsible for local implementation of the center's programs. Intergovernmental agreements between the center and county departments specify deliverables to be provided and related funding. The center also partners with the Association of Community Health Centers, which has a network of 20 federally qualified health centers across Arizona that support more than 140 points of service.

The AHDC also collaborates with local universities in Arizona to engage stakeholders and develop plans for addressing minority health disparities. These universities often provide technical assistance to the center, particularly on topics related to evaluation, methodologies, data metrics, and capacity building. In addition, the AHDC relies heavily on the Center for Rural Health at the University of Arizona for support addressing disparities in access to care among rural populations.

Another partner of the AHDC is the Public Health Prevention Bureau, which sponsors the "Health in Arizona Policy Initiative," of which the ADHC is a member. This effort focuses on statewide goals related to nutrition, physical activity, worksite wellness, school health, tobacco cessation, helping children with special needs, and addressing chronic disease.

## Funding

| | |
|---|---|
| Annualized budget (FY 2014) of state/territorial minority health entity (SMHE) across all income sources | $8,708,232 |
| Annual budget (FY 2014) of SMHE from state/territorial government | $7,575,670 |
| Largest funding source | State tobacco tax |
| Anticipated changes to budget in FY 2015 | None |

The total FY 2014 funding for the AHDC was $8,708,232. The majority of funding was procured at the state level through tobacco taxes ($6,935,431), lottery income ($520,000), the center's general fund ($120,239), and the general fund from the Office of the Director (funding amount not specified). Each state funding stream is appropriated annually. Federal funding came from the U.S. Office of Minority Health, State Partnership Initiative to Address Health Disparities grant, and the U.S. Health Resources and Services Administration Title V Maternal and Child Health Services Block Grant Program. The U.S. Office of Minority Health awarded the center $200,000 over 5 years beginning in August 2015.

# Arizona

## Arizona State Data

| Total Population[a]: 6,931,071 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 31.0 | 69.0 | 75.8 | 4.4 | 4.4 | 3.4 | 12.1 | 100.0 | NA |
| Percent of population medically uninsured[a] | 18.2 | 7.2 | 8.9 | 9.9 | 21.3 | 8.4 | 18.1 | 10.6 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 5.5 | 5.5 | 5.0 | 10.2 | 7.7 | SP | NC | 5.5 | 5.9 |
| Age-adjusted mortality rate[b] | 595.9 | 686.5 | 667.4 | 799.8 | 872.9 | 403.8 | NC | 675.8 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 11.7 | 15.7 | 15.1 | 15.6 | 19.1 | SP | 11.4 | 14.7 | 13.6 |
| Percent with diabetes[c] | 11.5 | 10.5 | 10.3 | 13.5 | 17.5 | SP | 12.8 | 10.8 | 10.8 |
| Percent with heart disease[c] | 3.3 | 4.7 | 4.8 | 2.8 | 1.9 | SP | 2.2 | 4.2 | 4.3 |
| HIV rate[d] | 284.0 | NC | 228.6 | 825.3 | 267.3 | 99.7** | 471.5 | 270.0 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 62.4 | 70.5 | 69.9 | 73.3 | 59.1 | SP | 58.2 | 68.3 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 51.7 | 66.5 | 65.5 | 58.2 | 50.5 | SP | 48.8 | 62.9 | 66.5 |
| Percent received flu vaccine[c] | 29.6 | 37.3 | 36.9 | 29.4 | 29.6 | SP | 26.4 | 35.2 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

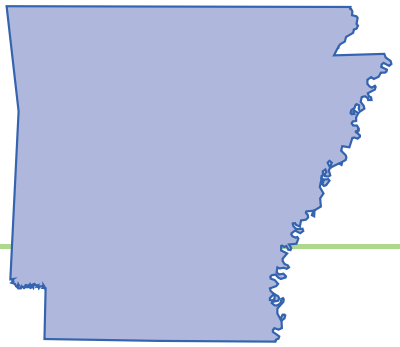
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 99.7 per 100,000 population (178 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 205.6 per 100,000 population (21 cases).

# Arkansas



## Introduction to Arkansas' Health Equity Activities

Arkansas had an estimated 2016 population of 2,988,000. Blacks/African Americans are the largest racial-ethnic minority population (16 percent), followed by Hispanics/Latinos (7 percent), Asian Americans and NHOPI (2 percent), and American Indians/Alaska Natives (1 percent). Persons self-identifying as multiracial or "other race" comprise 5 percent of the population.[1] Approximately 657,000 Arkansas residents live within a primary care health professional shortage area.[2]

In 1991, Arkansas established the Office of Minority Health and Health Disparities (OMHHD) to address concerns related to disparities in health status, especially among minority populations. The mission of the office is to provide leadership and promote heath equity for minority populations as defined by race/ethnicity, age, disability, education, gender, geographical location, income, and sexual orientation. In carrying out its mission, OMHHD is strategically placed under the Deputy Director for Public Health Programs to allow cross-cutting access to each ADH Center and collaborates with all programs to address the needs of minority populations.

### Arkansas Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Minority Health and Health Disparities |
| Strategic plan in place to address minority health or health equity | The Arkansas Department of Health's strategic plan includes a strategic plan regarding minority health. |
| Date strategic plan was last updated | 2015 |
| Assessment plan in place to measure progress toward reducing health disparities | Yes; the assessment plans are in the strategic plan and are specific to the goals of each center within the Department of Health. |
| Key strategies used to achieve health equity | • Hypertension and stroke awareness initiatives<br>• Healthy eating and exercise initiatives<br>• Infant mortality and expectant mother initiatives<br>• Teen pregnancy prevention |

## Organizational Structure

The ADH is a cabinet-level agency and reports directly to the Governor. The OMHHD has seven full-time staff, including the director, two health program specialists, a minority health manager, an epidemiologist, an administrative analyst and a nurse coordinator. Each staff member devotes 100 percent time to OMHHD activities. Staffing allocations are not expected to change during the next 2 years. In addition to these full-time positions, the Washington, DC-based Directors of Health Promotion and Education fellowship program and the University of Arkansas for Medical Sciences provide interns who work in the OMHHD.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Arkansas Department of Health | ADH |
| Arkansas Minority Health Commission | AMHC |
| Office of Minority Health and Health Disparities | OMHHD |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The OMHHD reports to the Deputy Director for Public Health Programs. The ADH is a cabinet-level agency and reports directly to the Governor |
| SMHE staffing (full-time equivalents) | 7 |
| Advisory committee or panel | Yes, although the advisory committee has not convened in 3 years |

## Program Goals and Activities

A strategic plan regarding minority health, health disparities, and health equity is integrated into the ADH strategic plan and has been available since prior to 2010. This strategic plan was last updated in 2015 (covering 2016–2019), and is updated every 4 years. Each ADH center (such as the Center for Health Protection and the Center for Health Advancement) has an assessment plan to measure goals related to health disparities; those plans are included in the ADH strategic plan. For example, the Family Health Branch's assessment plan includes measurement of reduction of teen pregnancies among African American females.

To set priorities and determine strategies, OMHHD staff and staff from ADH centers and branches come together to draft the ADH strategic plan. With input from ADH centers and branches, OMHHD staff examine disparity rates for the leading causes of death among different populations to identify and prioritize disparities. The OMHHD also has a legislative mandate to maintain and annually update a list of counties where life expectancies are 8 to 10 years shorter than in other counties. The counties are commonly referred to as "red counties" and the Red County report is annually compiled by the OMHHD. AMHC staff then use the list to assemble a workgroup of agencies that will focus on a year-long health-related improvement project.

The OMHHD promotes awareness of all at-risk populations, including those affected by racial, ethnic, disability, sexual orientation, and geographical location health disparities. Key strategies have included promoting healthy eating and exercise; it also has been working to reduce infant mortality and improve maternal health. To address hypertension and stroke disparities, the OMHHD developed the Arkansas Minority Barber and Beauty Shop Initiative, which aims to increase public awareness of disease prevention and management among African Americans and Latinos. The initiative, originally implemented in Pulaski County, has since been expanded to red counties through grant funding.

To improve healthy eating and exercise, the Governor's Office has endorsed a public-private partnership called Healthy Active Arkansas, which is a 10-year state plan to reduce obesity. Relatedly, the OMHHD started the Healthy Active Arkansas ambassador training program to disseminate obesity reduction information to minority communities. The program initially recruited training ambassadors from the pool of Miss Arkansas pageant contestants, as well as other beauty queen contestants from historically Black colleges and universities. The program now includes males, high school students, and college leaders on campus.

Several initiatives have been developed in collaboration with the Family Health Branch aimed at improving the health of minority women and children. For example, the OMHHD partnered with African American sororities and fraternities to start Sisters United and Brothers United, which is a community-based initiative that focuses on folic acid intake, flu shots during pregnancy, breastfeeding, and safe sleep for infants. Families United, a version of the initiative tailored to the Latino population in Arkansas, also addresses higher rates of gestational diabetes among Latino women. The OMHHD also assists with other campaigns, such as Mocha Café, a breastfeeding support group for women of color. The "Say Yes to Best" initiative encourages women in counties with low breastfeeding rates and high rates of sudden infant death syndrome to breastfeed, speak to lactation consultants before they give birth, and use safe portable bassinets. The OMHHD also is assisting the Family Health Branch in its efforts to encourage the use of long acting reversible contraceptives (LARCs) by African Americans and Latinos.

Another program, the Arkansas Minority Barber & Beauty Shop Health Initiative, was developed to increase public awareness about heart disease and stroke in a convenient location. Its primary objectives are to: screen for diabetes, high blood pressure, and cholesterol; educate communities about the importance of proper diet, physical exercise, and recognition of signs and symptoms of stroke and heart disease; and refer high-risk individuals identified through screening to local health units. Each year, with over 200 community volunteers, the OMHHD screens over 500 customers receiving services in local hair salons.

Lastly, the OMHHD seeks to better serve the Marshallese American population. The Marshallese population is most concentrated in the northwest portion of the state and was affected by a major mumps outbreak in 2016. This outbreak reached almost 3,000 cases statewide, and more than half of these cases were in the Marshallese community. Arkansas is home to the largest concentration of Marshall Islanders within the contiguous United States.

### Partnerships

| | |
|---|---|
| Primary collaborators | • African American Fraternities and Sororities<br>• Arkansas Children's Hospital<br>• Arkansas Minority Health Commission<br>• March of Dimes<br>• University of Arkansas for Medical Sciences |
| Contracts or memoranda of understanding with any partners | Yes, contracts are implemented for some partnerships (i.e., grant-funded projects). For example, the OMHHD has a contract with Arkansas Children's Hospital for Brother's United. |

Infant mortality reduction is a topic of several partnerships throughout the state. For example, the March of Dimes and the University of Arkansas for Medical Sciences have been key partners with the OMHHD in efforts to reduce infant mortality among minority populations. Together, they have hosted a forum called Let's Talk About Breastfeeding. In another partnership with the March of Dimes to increase awareness about infant mortality in African American communities, a blog was developed to follow the pregnancy of a local celebrity. Arkansas Children's Hospital holds monthly meetings, entitled Natural Wonders Meetings, as part of the Natural Wonders Partnership Council's efforts to decrease infant mortality. As noted above, the OMHHD works closely with the AMHC to address minority health priorities in red counties.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $523,686 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $338,686 |
| Largest funding source | Arkansas general revenue funds |
| Anticipated changes to budget | None anticipated. |

The total FY 2015 funding for the OMHHD was approximately $523,686. In FY 2015, the largest single source of funding was from ongoing state general revenue ($338,686). The remainder was received during the second year of a 5-year U.S. Office of Minority Health grant ($185,000) that funds the Arkansas Minority Barber and Beauty Shop Initiative. The AMHC receives $1,604,983 in funding, most of which comes from the Arkansas Tobacco Settlement Commission ($1,604,714); the remainder is allocated from state general revenue funding. The AMHC distributes some of its funding as mini-grants to other organization, but the OMHHD does not fund other organizations.

# Arkansas

## Arkansas State Data

| Total Population[a]: 2,988,248 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 7.2 | 92.8 | 76.6 | 15.7 | 0.7 | 1.6 | 5.3 | 100.0 | NA |
| Percent of population medically uninsured[a] | 23.5 | 7.4 | 7.8 | 8.0 | 15.9 | 11.6 | 18.8 | 8.5 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 8.1 | 6.7 | 11.2 | SP | SP | NC | 7.5 | 5.9 |
| Age-adjusted mortality rate[b] | 319.1 | 905.6 | 883.8 | 1019.2 | 314.7 | 454.5 | NC | 893.2 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 10.9 | 14.7 | 14.3 | 13.7 | 30.2 | 0.2 | 11.6 | 14.4 | 13.6 |
| Percent with diabetes[c] | 5.7 | 14.0 | 13.1 | 16.2 | 22.5 | 18.2 | 6.7 | 13.6 | 10.8 |
| Percent with heart disease[c] | 3.1 | 7.4 | 7.5 | 5.4 | 7.1 | 0.0 | 10.0 | 7.2 | 4.3 |
| HIV rate[d] | 224.6 | NC | 127.3 | 631.3 | 27.3 | 44.0** | 743.5 | 214.8 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 57.8 | 74.6 | 72.4 | 84.0 | 66.4 | 78.9 | 48.6 | 73.3 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 63.8 | 58.0 | 58.8 | 61.4 | 35.5 | 85.2 | 48.2 | 58.5 | 66.5 |
| Percent received flu vaccine[c] | 41.7 | 39.1 | 40.0 | 33.6 | 33.3 | 30.0 | 41.7 | 39.0 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 44.0 per 100,000 population (16 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 92.5 per 100,000 population (5 cases).

# California

## Introduction to California's Health Equity Activities

California had an estimated 2016 population of 39,250,000. Hispanics/Latinos are the largest racial-ethnic minority population (39 percent), followed by Asian Americans and NHOPI (15 percent), Blacks/African Americans (6 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 19 percent of the population.[1] Approximately 7,933,000 California residents live within a primary care health professional shortage area.[2]

In 2012, California statutorily mandated a restructuring of its public health program with the aim of achieving the highest level of health and mental health for all people—with a focus on socioeconomically disadvantaged populations—by addressing health disparities, and health equity priorities. Section 131019.5 of the California Health and Safety Code established the Office of Health Equity (OHE) within the California Department of Public Health (CDPH). Its purpose is to align state resources, decision-making, and programs to achieve optimal health for all people, including socioeconomically disadvantaged populations. Core activities of the OHE include conducting policy analysis, developing strategic policies and plans, and serving as a resource to other state agencies as they work to improve the social determinants of health, health care access and quality.

### California Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Health Equity (OHE) |
| Strategic plan in place to address minority health or health equity | Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity |
| Date strategic plan was last updated | 2015 |
| Assessment plan in place to measure progress toward reducing health disparities | Performance measures included in the strategic plan |
| Key strategies used to achieve health equity | • California Reducing Disparities Project[3]<br>• Health in All Policies Task Force[4]<br>• Let's Get Healthy California[5]<br>• Provide statewide leadership in policy, systems, and environmental change by improving health, equity, and environmental sustainability in California government decision-making, practices, and policies[6] |

## Organizational Structure

As the primary office responsible for addressing minority health, health disparities, and health equity in the state, OHE is housed within the California Department of Public Health and is composed of three units. First, the Community Development and Engagement Unit's focus is to strengthen the CDPH's ability to advise and assist other state agencies improve access to high quality of culturally and linguistically competent health care services. Additionally, the Health Equity Planning and Policy Unit brings a health equity focus to complex policy projects that require input and collaboration across multiple agencies and departments to achieve health, equity, and environmental sustainability.

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 California Department of Public Health's "California Reducing Disparities Project." Available on the CDPH website.

4 For more information, see the "Health in All Policies Resources" page at the California Department of Public Health Website.

5 Let's Get Healthy California information is available on the "Letsgethealthy.ca.gov" website.

6 This is the mission of the Health Equity Policy and Planning Unit of the Office of Health Equity, which contains the Health in All Policies and Climate Change and Health Equity programs.

The Policy Unit contains the Health in All Policies Task Force and the Climate Change and Health Program. Finally, the OHE's Health Research and Statistics Unit produces data for reports and provides information and technical assistance regarding health and mental health disparities to programs of the CDPH, state agencies, local health departments, and stakeholders.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| California Department of Public Health | CDPH |
| Office of Health Equity | OHE |

A group of experts, advocates, clinicians, and consumers who understand issues around disparities in health and mental health care, as well as health issues in underserved and underrepresented communities, serves as OHE's Advisory Committee. It is composed of representatives from state agencies and departments, local health departments, community-based organizations, and service providers working to advance health and mental health equity for vulnerable communities. The Advisory Committee also consults regularly with the Office regarding policy recommendations, strategic plans, and cross-sectoral work. This body helps advance OHE's goals and advises on the development and implementation of OHE's Strategic Plan.

The OHE is staffed by individuals dedicated to minority health, health disparities, and health equity initiatives; it does not share staff with other CDPH offices. Its deputy director is appointed by the governor and confirmed by the state Senate. Other senior staff include health program managers, a senior communications consultant, and a research scientist supervisor. Mid-level staff include a communications consultant, health program specialists, and research scientists. The office also hosts paid and unpaid college interns.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Office of Health Equity is an executive office within the California Department of Public Health |
| SMHE staffing (full-time equivalents) | 20 |
| Advisory committee or panel | Yes |

## Program Goals and Activities

California's OHE is legislatively mandated to establish a comprehensive, cross-sectoral strategic plan to eliminate health and mental health disparities and inequities. The strategic plan—*Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity*[7]— was first published in August 2015 and will be updated biennially. This plan seeks to promote equitable social, economic, and environmental conditions to achieve optimal health, mental health, and well-being for all. It includes a demographic analysis of health and mental health equity in California, and a strategic plan to address inequalities. The strategic plan interventions are based on three main priorities:

- Assessment—to yield knowledge of problems and possibilities
- Communication—to foster shared understanding
- Infrastructure development—to empower residents and institutions to act effectively within the health field, among potential health partners, and within local communities.

California is implementing many activities and initiatives to reduce health disparities and improve health equity. Launched in 2009, the California Reducing Disparities Project invests in community-defined, promising practices that address mental health disparities in five populations: African Americans, Asian/Pacific Islanders, Latinos, LGBTQ individuals, and

7 "Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity." Report to the Legislature and the People of California by the Office of Health Equity, California Department of Public Health, August 2015. Available on the CDPH website.

Native Americans. Phase 1 of the project, completed in 2014, focused on developing strategies to transform the public mental health system and identifying community-based promising practices in each of the five targeted populations. Phase 2 is to fund selected approaches across the five targeted populations with strong evaluation, technical assistance, and capacity building components.

In 2010, the state created the Health in All Policies (HiAP) Task Force, which is staffed through a partnership between the State Health Department, the Public Health Institute, and a cabinet-level body called the Strategic Growth Council. HiAP is a collaborative approach to improving the health of all people by incorporating health, equity, and sustainability considerations into decision-making across sectors and policy areas. The Task Force has 22 member state agencies, such as Environmental Protection, Transportation, Education, Social Services, and Housing and Community Development. The Task Force works to promote a government culture that prioritizes the health and equity of all Californians across policy areas, incorporates health and equity into state agency practices, and provides a forum for agencies to identify shared goals and opportunities to enhance performance through collaboration.

California is a leader in addressing climate change, which has many health impacts that harm communities facing health inequities first and worst. The Climate Change and Health Equity Program (CCHEP) embeds health and equity in California climate change policy and planning, and embeds climate change and equity in public health policy and planning. CCHEP works with local, state, and national partners to assure that climate change mitigation and adaptation activities have beneficial effects on health, while not creating or deepening health inequities. The program implements California's climate change laws and executive orders, contributing health equity considerations to grants, policies, and plans, and works to increase resilience to climate impacts by improving living conditions with and for people facing inequities. CCHEP provides health equity input into California's plans for transportation, housing, land use planning, and other systems that affect health outcomes and vulnerability to climate change impacts, and supports systems that facilitate robust community engagement in decisions that affect daily life for residents.

Another effort, Let's Get Healthy California (LGHC), identifies and highlights creative and effective efforts from across the state that are working to improve health and advance health equity. LGHC is a 10-year plan aiming to improve the health of Californians through collective action across six goal areas. LGHC identifies a set of indicators in key dimensions that, taken together, convey the state of California's health and well-being—at both the population and system level. Progress is evaluated by not only looking to improve statewide health outcomes but also to close the gaps across disparities.

### Partnerships

| | |
|---|---|
| Primary collaborators | • California Department of Health Care Services<br>• California Department of Transportation<br>• California Department of Corrections and Rehabilitation<br>• Governor's Office of Planning and Research<br>• Strategic Growth Council<br>• California Environmental Protection Agency<br>• Sierra Health Foundation<br>• The California Endowment<br>• California Healthcare Foundation<br>• Kaiser Family Foundation<br>• Local health departments<br>• Federal Reserve Bank of San Francisco |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. Additionally, interagency agreements may also be used |

The California OHE partners with governmental and nongovernmental agencies and organizations to eliminate health disparities and advance health equity. The office maintains an interagency agreement with the California Department of Health Care Services that outlines how they will work together to advance the Office's mission. This includes collaborating with the Mental Health Services Division of the Department of Health Care Services to partner, inform, and offer cultural and linguistic sensitivity technical assistance; collecting and analyzing data; and serving on the office's advisory committee.

# California

Through the Health in All Policies Task Force and Climate Change and Health Equity Program, the OHE has collaborated with other agencies within state government to promote health equity. For example, through the HiAP Task Force, staff work with the Department of Transportation to improve its grant-making language to make it more accessible, equitable, and inclusive of public health issues such as active transportation, activities to make walking easier, and improving safe and accessible cycling opportunities. Other examples include a partnership with the Department of Corrections and Rehabilitation and the Department of General Services to improve access to healthier food options in correctional facilities. The OHE regularly provides technical assistance, and sometimes contracts, to local health departments across the state.

The OHE has also partnered with nongovernmental stakeholders to evaluate minority health, health disparities, and health equity best practices and to align these efforts. The Sierra Health Foundation, California Endowment, Kaiser Family Foundation, the California Healthcare Foundation, the Federal Reserve Bank of San Francisco, and other entities have helped the office foster a climate for educating Californians about health disparities and inequities.

## Funding

| | |
|---|---|
| Annualized budget (FY 2017) of state/territorial minority health entity (SMHE) across all income sources | $20,445,867 (includes $15 million of the $60 million in one-time funding for pilot projects under the California Reducing Disparities Project related to behavioral health; funding awarded over 4 years) |
| Annual budget (FY 2017) of SMHE from state/territorial government | Approximately 90% of the Office of Health Equity funding comes from state initiatives |
| Largest funding source | State government |
| Anticipated changes to budget in FY 2018 | No |

The total FY 2017 funding for the OHE was $20,445,867. The office has several main funding sources. The Mental Health Services Act (MHSA) (Proposition 63) allocated $60 million over 4 years, beginning in fiscal year 2012 (without regard to fiscal years) for the California Reducing Disparities Project (CRDP). Additionally, the OHE, through the ongoing MHSA fund separate from the $60 million, received $2,230,000 (FY 2016) to support all personnel and administrative costs to oversee the CRDP. Another funding source is through the Air Pollution Control Fund of the California Global Warming Solutions Act of 2006 (AB 32, Nunez, Chapter 488, Statutes of 2006), which helps fund the integration of health equity considerations into California's climate change policies, grants, and plans. A small amount of funding is provided by the Centers for Disease Control and Prevention to help local health departments and the State prepare for and adapt to the health impacts of climate change. Approximately 90 percent of the office's funding comes from state initiatives, but the office is positioning itself to take advantage of national/federal funding in the future.

# California

## California State Data

| Total Population[a]: 39,250,017 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 38.9 | 61.1 | 59.6 | 5.8 | 0.7 | 14.7 | 19.2 | 100.0 | NA |
| Percent of population medically uninsured[a] | 12.4 | 4.5 | 6.8 | 6.6 | 11.5 | 4.9 | 11.9 | 7.6 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 4.4 | 4.2 | 4.2 | 8.9 | 6.8 | 3.5 | NC | 4.4 | 5.9 |
| Age-adjusted mortality rate[b] | 516.5 | 642.6 | 650.6 | 812.3 | 382.2 | 394.2 | NC | 616.9 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 10.3 | 14.2 | 13.1 | 17.9 | 13.4 | 9.0 | 12.7 | 12.8 | 13.6 |
| Percent with diabetes[c] | 11.0 | 9.8 | 9.5 | 10.5 | 13.4 | 11.8 | 11.3 | 10.2 | 10.8 |
| Percent with heart disease[c] | 2.3 | 3.8 | 3.8 | 2.5 | 2.9 | 2.4 | 2.3 | 3.4 | 4.3 |
| HIV rate[d] | 374.8 | NC | 370.0 | 1106.7 | 235.1 | 100.1** | 480.5 | 376.4 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 62.5 | 71.0 | 67.3 | 69.3 | 60.8 | 73.4 | 65.9 | 68.1 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 59.4 | 72.9 | 68.3 | 59.3 | 55.8 | 78.5 | 62.1 | 68.5 | 66.5 |
| Percent received flu vaccine[c] | 27.0 | 40.2 | 35.6 | 29.0 | 26.7 | 45.3 | 29.9 | 36.0 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

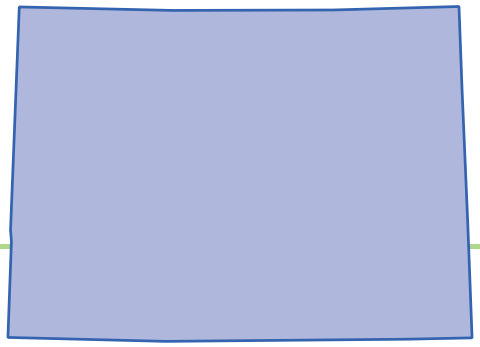
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 100.1 per 100,000 population (4,726 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 205.7 per 100,000 population (245 cases).

# Colorado



## Introduction to Colorado's Health Equity Activities

Colorado had an estimated 2016 population of 5,541,000. Hispanics/Latinos are the largest racial-ethnic minority population (21 percent), followed by Blacks/African Americans (4 percent), Asian Americans and NHOPI (3 percent), and American Indians/Alaska Natives (1 percent). Multiracial and persons self-identifying as Other Race comprise 7 percent of the population.[1] Approximately 1,069,000 Colorado residents live within a primary care health professional shortage area.[2]

The Colorado Department of Public Health and Environment (CDPHE) is made up of 11 divisions. The Office of Health Equity (OHE) falls under the Division of Community Relations, which also involves communications, emergency preparedness, and the Office of Planning Partnerships and Improvement. The Office of Health Disparities and the Minority Health Advisory Commission were officially created through Senate Bill 242 in May 2007. In 2013, House Bill 13-1088 changed the name of the office to the OHE and expanded it to serve lesbian, gay, bisexual, and transgender (LGBT), aging, disabled, low-socioeconomic, and geographic populations. The Minority Health Advisory Commission and the Interagency Health Disparities Leadership Council were consolidated into the Health Equity Commission, which advises OHE on minority health, health disparities, and health equity. The Commission is comprised of 13 community members and 2 state legislators (1 representative and 1 senator). Members are chosen based upon their geographic location, knowledge about health equity and environmental justice, and ability to effectively advise the CDPHE through the OHE.

### Colorado Minority Health Overview

| | |
|---|---|
| Name of state/territorial minority health entity | Colorado Office of Health Equity |
| Strategic plan in place to address minority health or health equity | No strategic plan was in place to address minority health or health equity at the time of data collection. Plans regarding minority health, health disparities, and health equity are included in a 2013 minority health report. In collaboration with philanthropic partners, the Office of Health Equity intends to create a comprehensive planning document in 2017. |
| Date strategic plan was last updated | N/A |
| Assessment plan in place to measure progress toward reducing health disparities | N/A. An assessment plan will be included with the 2017 strategic plan. |
| Key strategies used to achieve health equity | • Providing mandatory training to all staff on health equity and environmental justice<br>• Developing health equity policy encouraging all staff to think critically about serving minority populations<br>• Hiring new policy and community engagement staff in the Office of Health Equity<br>• Developing resources and tools to help staff think about how to incorporate health equity into their work |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

## Organizational Structure

The OHE has three full-time staff members who dedicate all of their time to minority health and health equity initiatives, but plans call for expansion to five full-time staff. Current full-time staff include the office's director, a policy analyst, and a community engagement specialist. An ongoing Health Equity Commission advises on minority health and health equity issues.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The OHE is housed within the Colorado Department of Public Health and Environment |
| SMHE staffing (full-time equivalents) | 3 |
| Advisory committee or panel | The Health Equity Commission |

## Program Goals and Activities

In 2013 the OHE published a Health Disparities Report. The purpose of the report was to identify strengths and disparities for groups in the 10 areas CDPHE identified as winnable public health battles. While the report may be viewed as a call to action, it is not a comprehensive planning document that can be used as a strategic plan. The OHE, with the help of philanthropic partners, aims to produce a strategic plan and accompanying assessment plan in 2017.

Without a strategic plan currently in place, the process by which minority health, health disparities, and health equity goals are set is still developing. A legislative mandate requires the OHE to exist and be funded by Colorado's general revenue. The mandate also specifies the populations that the OHE must serve, which include minorities, the LGBT population, older adults, and those with mental health issues. Currently, many governmental and nongovernmental agencies are compiling data about minority health. These agencies are the CDPHE, the Colorado Department of Health Care Policy and Financing (responsible for administering the state Medicaid program), the Department of Human Services, the Colorado Health Foundation, the Colorado Health Institute, the Colorado Public Health Foundation, and others. The Colorado Health Foundation is the largest private funder of health initiatives in the state and recently increased its focus on health equity. The Colorado Health Institute and the Colorado Public Health Foundation have been instrumental in developing policy related to minority health in the state. By late 2017 or early 2018, the OHE will assemble the data collection efforts of these agencies into a report.

The strategies OHE is currently leading to reduce health disparities and achieve health equity are part of the cultural change efforts within CDPHE to address health equity activities across the CDPHE. CDPHE initiated a policy, the Health Equity and Environmental Justice Principles, which encouraged, if not mandated, that all CDPHE staff seek opportunities to incorporate health equity and/or environmental justice into their work. To coincide with the implementation of this policy, the OHE developed a mandatory, online, 40-minute health equity and environmental justice training to assist in establishing a baseline across the CDPHE to inform all staff members about the CHPHE policy. To further support these efforts, the OHE is leading conversations with groups of 10–15 people in various divisions. The groups discuss specific examples of what it looks like to incorporate equity and justice into their work, how to be intentional in the use of data to drive decision-making, and how to avoid victim blaming when using data to tell the story of disparities.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Colorado Department of Public Health and Environment | CDPHE |
| Office of Health Equity | OHE |

To support the focus on CDPHE's new policy, the OHE started a major reorganization of its staff in December 2015. New hires include a community engagement specialist and a policy analyst, and OHE plans to hire a health equity and environmental justice trainer. Finally, since the OHE itself is small, the OHE needed to develop the skills of CDPHE in order to better support health equity activities. Through the meetings and conversations that are part of the strategy to get all staff to think critically about serving minority populations, the OHE staff heard that there was a need for practical steps that staff could take to be more intentional about working for equity, so another strategy was to develop tools to assist staff. One tool describes what resources staff should have in place prior to initiating engagement activities. Another tool is the equity action plan, which addresses the equity-related questions that a staff member might want to consider before attempting to develop programs to serve

marginalized communities. These OHE tools and training resources do not specifically address particular minority populations or other populations.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Colorado local public health departments<br>• Colorado nonprofit community<br>• CDPHE leadership |
| Contracts or memoranda of understanding with any partners | No partnerships include formal contracts or memoranda of understanding. |

In addition to the work described above, the OHE partners with governmental and nongovernmental organizations to work toward eliminating health disparities and advancing health equity in the state. For example, OHE's equity and justice training is not just available to state-level, public health staff. Local public health departments also have access to this training, but they are not mandated to receive the training as state employees are. OHE works with local health departments and acts as a resource to maintain interest and engagement in health equity activities. There is no formal contract with local public health departments, but the OHE is working to establish a certain number of formal relationships with these agencies by the end of 2017. The OHE interacts with the nonprofit community in a similar way by sharing OHE resources and tools, since the nonprofit community is where much of the work around equity and minorities takes place. The OHE has shared resources with community partners, including the African American Health Alliance, the Latino Chamber of Commerce, and the Women's Foundation of Colorado. The partnership with the CDPHE leadership focuses on promoting culture change within the 1,400-person department and encouraging involvement by leadership of the department's 11 divisions.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $575,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $425,000 |
| Largest funding source | State government |
| Anticipated changes to budget | Possible (as reported at the time of data gathering) |

The total FY 2015 funding for the OHE was $575,000. This funding is separate from other funding for CDPHE. In FY 2015, the office had three key funding sources: the state tobacco tax funding ($225,000); the State of Colorado general revenue funding ($200,000); and Federal Prevention Block Grant funding ($150,000). All these funding sources and amounts have been ongoing. The OHE did not provide any funding to partners or other entities in FY 2015, but it awards Health Disparities Grants totaling approximately $5,000,000 every 3 years to nonprofit organizations throughout the state to work on reducing health disparities among minority and marginalized populations. The grants were last made available in 2015. If changes occur in federal priorities, the level of funding for OHE might change.

# Colorado

## Colorado State Data

| Total Population[a]: 5,540,545 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 21.3 | 78.7 | 84.2 | 4.2 | 0.9 | 3.3 | 7.4 | 100.0 | NA |
| Percent of population medically uninsured[a] | 17.0 | 5.5 | 7.4 | 7.4 | 15.4 | 6.8 | 14.4 | 8.0 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 5.1 | 4.2 | 4.4 | 7.7 | SP | SP | NC | 4.7 | 5.9 |
| Age-adjusted mortality rate[b] | 666.3 | 668.2 | 676.1 | 725.0 | 496.5 | 412.7 | NC | 669.5 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 10.8 | 14.4 | 13.6 | 14.3 | 16.2 | 13.3 | 19.2 | 13.9 | 13.6 |
| Percent with diabetes[c] | 8.2 | 6.2 | 6.4 | 7.6 | 11.8 | 3.5 | 9.3 | 6.6 | 10.8 |
| Percent with heart disease[c] | 2.5 | 3.2 | 3.1 | 2.0 | 4.7 | 0.6 | 2.7 | 3.0 | 4.3 |
| HIV rate[d] | 282.9 | NC | 213.3 | 947.9 | 205.9 | 85.1** | 289.1 | 253.6 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 56.6 | 64.7 | 63.3 | 69.1 | 61.5 | 64.8 | 60.0 | 63.4 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 57.1 | 70.0 | 68.8 | 54.9 | 62.3 | 69.5 | 62.7 | 67.8 | 66.5 |
| Percent received flu vaccine[c] | 39.9 | 43.6 | 43.1 | 39.4 | 48.6 | 46.3 | 38.3 | 43.0 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

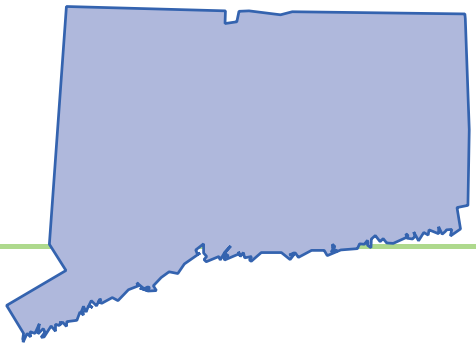
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 85.1 per 100,000 population (118 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 220.8 per 100,000 population (13 cases).

# Connecticut



## Introduction to Connecticut's Health Equity Activities

Connecticut had an estimated 2016 population of 3,576,000. Hispanics/Latinos are the largest racial-ethnic minority population (16 percent) followed by Blacks/African Americans (11 percent), Asian Americans and NHOPI (5 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 8 percent of the population.[1] Approximately 459,000 Connecticut residents live within a primary care health professional shortage area.[2]

In 2014, Public Act 14-231 created the Connecticut Department of Public Health (CDPH)'s Office of Health Equity (OHE), replacing CDPH's former Office of Multicultural Health. The OHE operationalizes the CDPH's priority to "champion a culture of health equity."[3] Its specific mission is "to improve the health of all Connecticut residents by working to eliminate differences in disease, disability and death rates among ethnic, racial and other population groups that are known to have adverse health status or outcomes."[4] Housed within the CDPH's Public Health Systems Improvement division, the OHE is tasked with ensuring that health equity is a crosscutting principle in all CDPH programs, data collection, and planning efforts.

### Connecticut Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Health Equity |
| Strategic plan in place to address minority health or health equity | The Office of Health Equity released the *Connecticut Department of Public Health Office of Health Equity Strategic Plan 2015-2018* in 2015, which it updates annually, as needed.[5] |
| Date strategic plan was last updated | 2016 |
| Assessment plan in place to measure progress toward reducing health disparities | The Office of Health Equity monitors progress through the Healthy Connecticut 2020 Performance Dashboard. |
| Key strategies used to achieve health equity | • Measuring the health equity impact of Connecticut Department of Public Health policies and programs<br>• Implementing a language access plan<br>• Identifying and monitoring indicators of health equity<br>• Developing Prevention Service Centers via State Innovation Model Test Grant<br>• Workforce development training in health equity |

## Organizational Structure

The OHE is located within the Office of the Commissioner as part of Public Health Systems Improvement, an office focused on improving public health structures, systems, and outcomes. The OHE moved to Public Health Systems Improvement in December 2010 to be in a better position to integrate health equity into the agency's ongoing program and planning efforts.

The OHE has two full-time staff members who dedicate their time to health equity initiatives, including the program director and one epidemiologist. Another epidemiologist from the Community,

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.
3 Connecticut Department of Public Health Strategic Map Update 2015–2018: Addendum 1 to Agency Strategic Plan 2013–2018. Available on the CDPH website. Last accessed 7/14/2017.
4 Connecticut Department of Public Health: Office of Health Equity website. Last accessed 7/14/2017.
5 Connecticut Department of Public Health Office of Health Equity Strategic Plan 2015–2018. Available on the CDPH website. Last accessed 7/14/2017.

Family, and Prevention section of the CDPH dedicates about 10 percent of time to health equity initiatives, focusing specifically on tracking and analyzing disparities found in chronic disease data. The OHE occasionally engages community health workers to support health equity activities.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Office of Health Equity is housed within the Connecticut Department of Public Health. |
| SMHE staffing (full-time equivalents) | 2 |
| Advisory committee or panel | Connecticut Multicultural Health Partnership, and Advisory Council of the Connecticut Health Improvement Coalition |

## Program Goals and Activities

Launched in 2015, the OHE's strategic plan acts as a blueprint for integrating health equity principles into the CDPH's programs, plans, and policies. The plan is publicly available on the OHE's website and updated, as needed, on an annual basis. The OHE monitors progress of the strategic plan through the CDPH's publicly available Healthy Connecticut 2020 Performance Dashboard, which tracks population indicators, performance measures, and health disparities for seven major focus areas, including health equity, cultural competency, and language services.

Assisted by organizations like the Connecticut Multicultural Health Partnership and guided by findings from the Healthy Connecticut 2020 State Health Assessment and the State Health Improvement Plan, the CDPH and the OHE identify health equity priorities as part of its strategic planning process. Additional priorities emerged when the CDPH received recognition from the Public Health Accreditation Board in March 2017, a distinction earned by 21 states that have met or exceeded national recognized public health standards around, among other topics, health equity.

OHE activities to reduce disparities include an effort to quantify the health equity impact of CDPH policies and programs. Led by the CDPH Government Relations Office, the OHE helped to institute agency-wide guidance documents to ensure that the CDPH is promoting health equity across all its efforts. Such documents help CDPH staff review the health equity impact of proposed legislation or policy changes. The OHE also helped create a checklist for grant proposals to document that applications address health equity concerns. Moving forward, the OHE will monitor the extent to which these documents are used throughout the CDPH.

The OHE aims to build the knowledge and skills of CDPH staff through health equity training and education activities. For example, the OHE developed an online training focused on the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). The training is mandatory for all new CDPH employees and is available to local health departments and social service providers in Connecticut. The OHE also compiled the Health Equity Toolkit (i.e., a set of resources and tools designed to help CDPH staff, partners, and local health departments understand health equity) and is planning trainings for its use. Additionally, the OHE will continue to promote the National CLAS Standards in Connecticut through training, workshops, and online resources.

Another strategy led by the OHE is the implementation of a language access plan. To support this strategy, the OHE collaborated with an internal CDPH workgroup to translate documents posted on the web, develop a language access chart, and improve signage in public health buildings. For example, the workgroup created language identification or "I speak" cards translated into the top 10 languages spoken in Connecticut. It also developed a process to support implementation and both monitor and evaluate use of this language access plan.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Connecticut Department of Public Health | CDPH |
| Office of Health Equity | OHE |

In a collaborative effort with CDPH's broader Public Health Systems Improvement division, the OHE works to identify and monitor indicators of health equity. The OHE also has been working with programs within the CDPH to develop and launch additional health equity dashboards to improve the CDPH's ability to identify additional disparities and monitor the impact of CDPH efforts to eliminate them.

The OHE also supports the development of Prevention Service Centers, funded through a State Innovation Model Test grant from the Centers for Medicare and Medicaid Innovation, to improve access to evidence-based community services and encourage investments in community health. Coordinated through the Office of the Lieutenant Governor and the Office of the Healthcare Advocate, these centers will be established in geographic areas experiencing significant disparities and will focus on three preventable and treatable conditions: diabetes, asthma, and hypertension.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Connecticut Multicultural Health Partnership<br>• Connecticut Health Improvement Coalition<br>• Local health departments |
| Contracts or memoranda of understanding with any partners | No partnerships include formal contracts or memoranda of understanding. |

Although it has no contracts or memoranda of understanding with any partners, the OHE engages governmental and nongovernmental organizations to collaboratively eliminate health disparities and advance health equity in Connecticut. A key partner is the Connecticut Multicultural Health Partnership, a statewide coalition of social service organizations, public health entities, advocacy groups, academic institutions, small businesses, and community members. The former CDPH Office of Multicultural Health established the Connecticut Multicultural Health Partnership in 2008. Since then, the partnership has played a lead role in implementing National CLAS Standards in Connecticut. The OHE and the Connecticut Multicultural Health Partnership have worked with local health departments on trainings and implementation of National CLAS Standards.

Another partner is the Connecticut Health Improvement Coalition, a consortium of community organizations and statewide agencies working together to implement Healthy Connecticut 2020, Connecticut's State Health Improvement Plan. In 2016, the OHE worked closely with Public Health Systems Improvement to create a policy agenda for the coalition. They identified policies for the 2017 state legislative session that would improve health outcomes based on the objectives set in the State Health Improvement Plan. For example, the Maternal, Infant, and Child Health team focused on building support for paid family leave legislation. Another agenda item focused on reducing the prevalence of and disparities in childhood lead poisoning through the adoption of a property maintenance code. Also on the agenda was a proposal by the Commissioner of Public Health to integrate local health departments into districts. In 2016, Connecticut had 72 local health departments, and the services they provided varied by geographic location. The goal for integration was to improve service delivery and make it more equitable.

The OHE also collaborates with a variety of state agencies and departments, nonprofit organizations, and academic institutions on health equity activities.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $631,806 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $487,008 |
| Largest funding source | State government |

The total FY 2015 funding for the OHE was $631,806. In FY 2015, the office had two funding sources: The State of Connecticut ($487,008) and a 2-year State Partnership Initiative to Address Health Disparities grant from the U.S. Office of Minority Health ($144,798). The last year of the State Partnership Grant was FY 2015. State funding is expected to remain relatively stable in future years. The OHE did not provide funding to other governmental or nongovernmental entities for health equity activities in FY 2015.

# Connecticut

## Connecticut State Data

| Total Population[a]: 3,576,452 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 15.7 | 84.3 | 76.7 | 10.7 | 0.3 | 4.6 | 7.7 | 100.0 | NA |
| Percent of population medically uninsured[a] | 12.1 | 3.5 | 4.0 | 5.7 | 14.4 | 6.0 | 10.9 | 4.8 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 7.7 | 4.9 | 4.5 | 12.8 | SP | SP | NC | 5.7 | 5.9 |
| Age-adjusted mortality rate[b] | 504.8 | 662.0 | 658.0 | 707.5 | 111.6 | 329.8 | NC | 654.0 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 19.5 | 15.0 | 15.0 | 17.6 | 12.6 | 12.6 | 21.2 | 15.5 | 13.6 |
| Percent with diabetes[c] | 10.8 | 9.7 | 9.4 | 14.9 | 9.6 | 6.0 | 10.9 | 9.9 | 10.8 |
| Percent with heart disease[c] | 1.9 | 3.9 | 4.1 | 2.0 | 4.8 | 1.0 | 2.1 | 3.6 | 4.3 |
| HIV rate[d] | 829.9 | NC | 145.4 | 1140.8 | 179.8 | 69.1** | 536.6 | 338.7 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 72.0 | 76.8 | 76.0 | 82.7 | 58.9 | 71.5 | 71.5 | 76.1 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 69.6 | 79.8 | 80.1 | 74.7 | 54.9 | 76.0 | 68.5 | 78.4 | 66.5 |
| Percent received flu vaccine[c] | 35.3 | 44.1 | 44.7 | 37.1 | 28.5 | 43.0 | 35.7 | 43.2 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 69.1 per 100,000 population (92 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 377.0 per 100,000 population (4 cases).

# Delaware

## Introduction to Delaware's Health Equity Activities

Delaware had an estimated 2016 population of 952,000. Blacks/African Americans are the largest racial-ethnic minority population (22 percent), followed by Hispanics/Latinos (9 percent), Asian Americans and NHOPI (4 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 5 percent of the population.[1] Approximately 233,000 Delaware residents live within a primary care health professional shortage area.[2]

Within the Delaware Department of Health and Social Services, the Division of Public Health (DPH) Bureau of Health Equity (BHE) is dedicated to addressing issues affecting the health of minority populations. The mission of the BHE is "to promote and advocate for policy, programs, services, and initiatives which will eliminate the impact of the social determinants of health to ensure all Delawareans can achieve their optimal health with a special focus on the underserved populations of Delaware."[3] The BHE seeks to reduce health disparities of minority populations including racial-ethnic minorities, people with disabilities, women, and individuals identified as lesbian, gay, bisexual, transsexual, and questioning (LGBTQ). The DPH uses a health equity lens when providing services and carrying out activities.

### Delaware Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Division of Public Health, Bureau of Health Equity |
| Strategic plan in place to address minority health or health equity | The Division of Public Health's *Health Equity Strategy Map* outlines strategies for achieving health equity.<br>The *Delaware Division of Public Health 2014 – 2017 Strategic Plan* is an integrated plan with health equity as a strategic priority. |
| Date strategic plan was last updated | The *Division of Public Health's Health Equity Strategy Map* is updated annually, as necessary.<br>The *Delaware Division of Public Health 2014 – 2017 Strategic Plan* was last updated August 2014. |
| Assessment plan in place to measure progress toward reducing health disparities | Components of the Division of Public Health's *Health Equity Strategy Map* include data-driven objectives.<br>The *Delaware Division of Public Health 2014 – 2017 Strategic Plan* includes assessment components to measure progress toward outcomes, objectives, and strategic priorities. |
| Key strategies used to achieve health equity | • Increasing knowledge and awareness of health equity and social determinants of health<br>• Implementing a health in all policies approach<br>• Increasing cultural competency |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 Bureau of Health Equity. Health Equity homepage. Last accessed July 22, 2017.

## Organizational Structure

The DPH leadership team serves as an informal advisory committee to the BHE. The DPH leadership team meets monthly to review the DPH Health Equity Strategy Map and update progress toward meeting objectives. The BHE is housed within the DPH. The Office of Minority Health and the Office of Women's Health are both within the BHE. The BHE addresses minority health through these offices.

The BHE has two full-time staff members and one part-time staff member who work on health equity. However, all DPH staff work to achieve health equity. Full-time staff include the BHE chief and the director of the Office of Women's Health; the latter position is vacant. The one part-time (80 percent full-time) administrative specialist works on initiatives and activities at the BHE exclusively. One public health associate, funded through the U.S. Centers for Disease Control and Prevention (CDC), worked on initiatives and activities at the BHE. Certain staff from the DPH volunteer some of their time to BHE initiatives and activities.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Bureau of Health Equity is housed within the Division of Public Health of the Delaware Department of Health and Social Services |
| SMHE staffing (full-time equivalents) | 2 |
| Advisory committee or panel | Unavailable |

## Program Goals and Activities

The DPH has developed a structured approach for achieving health equity, which it calls the *Health Equity Strategy Map*. Created in 2012, the map illustrates the role of assessment components in reducing health disparities and guides the BHE in setting priorities.[4] The DPH leadership team meets monthly both to review the *Health Equity Strategy Map* objectives and to monitor progress in achieving them; it plans to update the document in 2017. In addition, the DPH created the *Delaware Division of Public Health 2014 – 2017 Strategic Plan* between September 2013 and August 2014. This plan identifies four strategic priorities: "Promote Healthy Lifestyles, Improve Access to High Quality and Safe Healthcare, Achieve Health Equity, and Improve Performance."[5] By September 2017, the DPH leadership team intends to form a Strategic Plan Action Committee to develop and plan a new DPH strategic plan for 2018 through 2022.[6]

To help set priorities, the BHE brings together health care stakeholders from public, nonprofit, and private agencies and organizations for an annual health equity summit. Through the summit the BHE offers a vehicle to provide input on issues not currently addressed, seek feedback from attendees, and conduct county-level workshops. During these workshops, community members, nonprofit organizations, and private entities offer their insights about a range of health issues. The feedback then informs the BHE's priorities and goalsetting activities for the upcoming year.

The BHE seeks to address health disparities through several strategies, including increasing knowledge and awareness of health equity and social determinants of health, addressing health equity through a Health in all Policies approach, and increasing cultural competency. It operationalizes these strategies by collaborating with the DPH to identify high-priority areas ("hot-spots"), with local health and other agencies to address equity issues in the hot spots, and with the nongovernmental organizations that host activities celebrating minority health month.

Using a Health in all Policies approach and a systems perspective, the BHE aims to bring together health and non-health sectors to enhance agency and organization capacity for meeting the needs of underserved individuals. The BHE has formed a Health in all Policies

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Bureau of Health Equity | BHE |
| Division of Public Health | DPH |

4 Division of Public Health. Health Equity Strategic Map. Available on the Delaware Division of Public Health website. Last accessed July 22, 2017.

5 Delaware Health and Social Services, Division of Public Health. Delaware Division of Public Health 2014-2017 Strategic Plan. Available on the Delaware Division of Public Health website. Last accessed July 22, 2017.

6 Ibid.

# Delaware

Collaborative that includes individuals both from governmental agencies and the private sector to determine whether proposed policies pose a positive or neutral impact on health. As part of this effort, the BHE trains individuals participating in the collaborative who, in turn, will train others in their respective organizations and agencies.

Twice a year, the BHE provides cultural competency training that is mandatory to all public health staff.

It also offers the training to health care providers, such as staff at federally qualified health centers and clinicians outside of public health. The BHE also works with outside organizations to assess cultural competency levels of DPH staff and DPH services and to create an implementation plan for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards).

## Partnerships

| | | |
|---|---|---|
| Primary collaborators | • AIDS Delaware<br>• Autism Delaware<br>• Beautiful Gate Outreach Center<br>• Breastfeeding Coalition of Delaware<br>• Cancer Support Community<br>• Cape Pharmacy<br>• Children & Families First<br>• Christiana Care Health Services<br>• Cross Cultural Health Care Program<br>• Delaware Department of Education<br>• Delaware Coalition Against Domestic Violence<br>• Delaware Department of Health and Social Services, Division for the Visually Impaired<br>• Delaware Department of Health and Social Services, Division of Public Health | • Delaware Department of Health and Social Services, Division of Services for Aging and Adults with Physical Disabilities<br>• Delaware Department of Justice<br>• Delaware Healthcare Association<br>• Delaware Hospice<br>• Doctors Pathology Services<br>• Each One Teach One<br>• Goeins-Williams Associates<br>• La Red Health Center<br>• Latin American Community Center<br>• Metropolitan Wilmington Urban League<br>• Planned Parenthood of Delaware<br>• Quality Insights<br>• Social Solutions<br>• Susan G. Komen |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. | |

To reduce health disparities, the BHE works with a broad range of governmental, nongovernmental, and private partners. For example, the BHE collaborates with the DPH to identify areas with high levels of disease burden and poverty. The DPH, in turn, sends health educators to such hot-spots, where they engage and educate individuals, community-based health agencies and organizations, and those serving priority populations about social determinants of health and health equity issues. These health educators also work with non-health agencies, such as the state's Department of Justice and Department of Education, to address a range of priority issues in hot-spot areas. The BHE partners with state-level departments in other capacities, as well. At its 2016 Health Equity Summit, for example, the Department of Education presented on its own health equity initiatives and activities, including collaborations it has developed with private agencies that fund nurse-provided health care services in schools.

In an effort to provide HIV-related services to at-risk populations, such as screening and treatment, the DPH formally partners with Christiana Care Health Systems (a statewide healthcare provider), the Latin American Community Center (which provides health and social services particularly to African American and Hispanic/Latino Delaware residents, including pediatric lead abatement treatments), and the Beautiful Gate Outreach Center. The BHE provides these partners with funding to commemorate important equity-related events, such as minority health month.

The BHE previously partnered with Georgetown University to survey public health staff regarding the National CLAS Standards. More recently, it has contracted with Goeins-Williams Associates to evaluate application of the National CLAS Standards by conducting focus groups with DPH service recipients. The BHE also collaborates with another organization to review findings from both the public health staff survey

and the focus group assessment, and then develop a National CLAS Standards implementation plan.

Additionally, the BHE and DPH collaborate with divisions within the Delaware Department of Health and Social Services, including the Division of Services for Aging and Adults with Physical Disabilities and the Division for the Visually Impaired. Nongovernmental organizations with whom the BHE and DPH partner include: AIDS Delaware, Autism Delaware, the Breastfeeding Coalition of Delaware, the Cancer Support Community, Cape Pharmacy, Children & Families First, Cross Cultural Health Care Program, Delaware Coalition Against Domestic Violence, Delaware Healthcare Association, Delaware Hospice, Doctors Pathology Services, Each One Teach One, La Red Health Center, Metropolitan Wilmington Urban League, Planned Parenthood of Delaware, Quality Insights, Social Solutions, and the Susan G. Komen Foundation.

## Funding

| | |
|---|---|
| Annual budget (FY 2017) of state/territorial minority health entity (SMHE) across all income sources | Unavailable |
| Annual budget (FY 2017) of SMHE from state/territorial government | $319,300 |
| Largest funding source | Delaware government |
| Anticipated changes to budget | None |

The total FY 2015 funding for the BHE was $363,000 (or $557,300 or $607,300). The BHE receives $319,300 from the Delaware government for health equity initiatives and activities. For FY 2015, the BHE received $50,000 in federal grants. From 2015 to 2019, the BHE also received a federal grant for violence prevention from the CDC, through the Office of Women's Health, for $238,000 a year. The BHE funds several nongovernmental organizations, including the Latin American Community Center ($5,104), Beautiful Gate Outreach Center ($2,500), and Goeins-Williams Associates ($31,480). The BHE does not anticipate funding changes in the next 2 years.

# Delaware

## Delaware State Data

| Total Population[a]: 952,065 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 9.1 | 90.9 | 69.2 | 21.7 | 0.4 | 4.1 | 4.6 | 100.0 | NA |
| Percent of population medically uninsured[a] | 15.9 | 5.3 | 5.6 | 7.5 | 6.4 | 4.7 | 11.4 | 6.2 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 9.5 | 7.9 | 13.4 | SP | SP | NC | 9.1 | 5.9 |
| Age-adjusted mortality rate[b] | 502.7 | 755.0 | 749.3 | 803.1 | 340.2 | 277.8 | NC | 746.2 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 10.9 | 12.8 | 11.5 | 16.6 | 20.0 | 12.9 | 15.6 | 12.9 | 13.6 |
| Percent with diabetes[c] | 7.5 | 10.9 | 10.3 | 12.9 | 5.2 | 7.2 | 11.0 | 10.8 | 10.8 |
| Percent with heart disease[c] | 1.0 | 4.2 | 5.0 | 1.6 | 0.6 | 1.2 | 3.3 | 4.0 | 4.3 |
| HIV rate[d] | 446.3 | NC | 181.8 | 1133.4 | 116.4 | 23.0** | 910.6 | 404.9 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 72.2 | 79.2 | 77.2 | 86.3 | 90.6 | 65.6 | 82.6 | 79.2 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 54.3 | 68.4 | 70.8 | 61.7 | 43.2 | 68.7 | 57.1 | 67.9 | 66.5 |
| Percent received flu vaccine[c] | 38.1 | 41.8 | 45.3 | 29.6 | 23.4 | 51.6 | 41.1 | 41.8 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

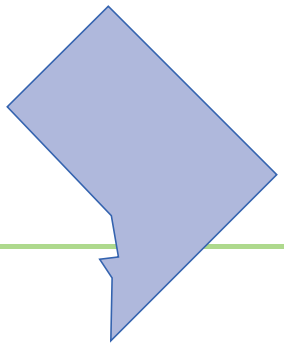
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 23.0 per 100,000 population (7 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 362.3 per 100,000 population (1 case).

# District of Columbia



## Introduction to District of Columbia's Health Equity Activities

The District of Columbia had an estimated 2016 population of 681,000. Blacks/African Americans are the largest racial-ethnic minority population (47 percent), followed by Hispanics/Latinos (11 percent), Asian Americans and NHOPI (4 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 8 percent of the population.[1] Approximately 249,000 District of Columbia residents live within a primary care health professional shortage area.[2]

In 2015, the District of Columbia Department of Health (DOH) created the Office of Health Equity (OHE) by administrative order. Its mission is to address the root causes of health disparities—beyond health care and health behaviors—by supporting multi-sectorial efforts to enable all DC residents to reach their optimal health.[3] The OHE's overarching goal is to improve the context for equitable opportunities for health in the District of Columbia. Based on the recently released DC Health Systems Plan,[4] barriers to health care access are less tied to quantity and relate more to complementary issues, such as transportation, cost, cultural competency, and hours of operation. Over the last decade, the District of Columbia's focus, supported by major investments in primary care facilities across the city, means that DC now has a network of well-distributed Federally Qualified Health

### District of Columbia Minority Health Overview

| | |
|---|---|
| Name of state/territorial minority health entity | District of Columbia Department of Health, Office of Health Equity |
| Strategic plan in place to address minority health or health equity | Yes. The District of Columbia Department of Health's *DC Healthy People 2020* strategies directly reference promoting health equity and addressing health disparities and disparate populations. |
| Date strategic plan was last updated | 2016 |
| Assessment plan in place to measure progress toward reducing health disparities | The District of Columbia Department of Health's *DC Healthy People 2020* (shared community agenda) includes over 160 objectives, many of which measure and track disparate outcomes by race, ethnicity, gender, age, and/or geography. |
| Key strategies used to achieve health equity | Promoting a multi-sectorial health policies approach across public, private, and nonprofit sectors. This is operationalized by applying a 3-pronged strategy, including the following:<br>• Building multi-sector collaborations<br>• Leveraging community-based participatory research<br>• Demonstrating health equity practice change.<br>**Note:** OHE will release the inaugural "Health Equity Report" for the District of Columbia in winter 2017 |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 Government of the District of Columbia Department of Health. Office of Health Equity website. Last accessed 1/24/2018.

4 Government of the District of Columbia Department of Health (May 2017). Draft District of Columbia Health Systems Plan. Available at the DOH website. Last accessed: 1/24/2018

Centers (FQHCs) and hospital-based private and specialized practices. As a consequence, although isolated gaps may exist, capacity is not the leading issue. A recent assessment shows that residents frequently opt to travel significant distances to access primary care services. This is despite the fact that there are access points in their communities. Overall, while some gaps and barriers exist—especially related to specialty care services—the District's greatest challenges relate to the social determinants of health—income, race, education, and transportation—which represent the critical barriers to care.

## Organizational Structure

In 2015, a DC Department of Health (DOH) administrative order established the OHE within DOH to address the root causes of health disparities. The DC Commission on Health Equity—developed under DC Act 21-44 "Commission on Health Equity Amendment Act of 2016" (August 18, 2016), was launched June 2017. It will consist of nine voting and eight non-voting members; the former must have expertise in particular topics, including health disparities, social and human services, early learning and education, minority communities, economic development, and ecology and the environment.[5,6] The Commission will serve in an advisory capacity to the OHE, DOH, the mayor, and the DC Council.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | OHE is a division of the District of Columbia Department of Health—it is one of 6 DOH Administrations |
| SMHE staffing (full-time equivalents) | 5 |
| Advisory committee or panel | Commission on Health Equity—launched June 2017 |

The OHE has five full-time staff members dedicated to addressing the root causes of health disparities and health inequities, increasing opportunities for health, and promoting health equity. Full-time OHE staff include the director, two public health analysts, a public health advisor, and a community engagement coordinator. In FY16, the OHE also had two student interns (in public health and urban planning) from George Washington University. The new Commission on Health Equity will have a total of 17 (unpaid) advisory commissioners, appointed by the mayor and DC Council.

## Program Goals and Activities

The DOH has an integrated strategic approach to addressing health disparities and health inequities and promoting health equity. Addressing the social determinants of health is one of DOH's five Strategic Priorities. All six DOH Administrations—including the OHE—are charged to integrate addressing health disparities and inequities and promoting health equity as a priority in all their work.

The District of Columbia Department of Health's *DC Healthy People 2020* was published in April 2016. Also of note, DOH recently released the *DC Health Systems Plan* (2017), which focuses more specifically on the Health Care Delivery System. It includes specific goals under Community Health Improvement, to promote health equity, improve health outcomes, and reduce disparities.

*DC Healthy People 2020*, a shared community agenda focusing on population health improvement, was developed as a multi-sectorial collaboration using a health equity lens. It recommends over 80 strategies that focus on social and structural determinants of health and changing the context through policy, aiming to address health disparities and disparate populations.[7] *DC Healthy People 2020* includes assessment components, via over 160 objectives that are tracked over time. At the time of data collection, the DOH Office of Policy Planning and Evaluation (CPPE) was developing the DC Health Systems Plan, focused on the health care delivery system. Simultaneously, the OHE was developing a Health Equity Report, as well as the launch the Commission on Health Equity, both expected to be completed prior to publication of this report.

The OHE mission charges this administration to focus on the root causes of health disparities, "beyond health care and health behaviors." The OHE therefore emphasizes the need to act on the social determinants of health, outside of the traditional health care and

5 Council of the District of Columbia (2014). D.C. Act 20-484.

6 Council of the District of Columbia. Law 2-192, Commission on Health Disparities Establishment Act of 2014.

7 Government of the District of Columbia Department of Health (April 2016). DC Healthy People 2020 Framework.

health delivery systems. The OHE provides leadership within DOH and across the District of Columbia in the practical application of health in all polices, programs, and practices. The data and evidence confirm that place and race matter for health in the District. Upon release of the Health Equity Report 2017, the OHE in collaboration with the Commission on Health Equity (CHE) will hold community conversations across the District, to inform priority setting focused on improving opportunities for health.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| District of Columbia Department of Health | DOH |
| District of Columbia Office of Health Equity | OHE |

The OHE also promotes a shared community agenda to achieve health equity, and uses several major strategies to reduce health inequities. To promote and achieve health equity, the OHE recognizes that public health activities alone cannot control most social determinants of health, and that clinical medicine alone cannot prevent or correct all adverse outcomes. For these reasons, the OHE seeks to develop data-driven, evidence-based, and evidence-informed strategies that leverage multi-sector collaborative partnerships. The OHE uses a "health in all policies" approach to improving community health and equity; it serves as a liaison and technical adviser to its five sister DOH Administrations, District Government agencies, private and nonprofit partners, health care partners, and community groups and residents. For instance, in 2016, the OHE worked with the District of Columbia Department of Transportation and other partners to implement "Vision Zero," an initiative to eliminate traffic fatalities and advance pedestrian and bicycle safety.

Another major OHE strategy leverages community-based participatory research. The OHE defines "community" to include nonprofit organizations, hospital practitioners, agencies, and others. The OHE seeks to apply data-driven and evidence-based research methods, tools, and practices—such as geographic information systems (GIS) analysis—and to publish reports with community partners to build an evidence base to inform policymaking. It also seeks to measure social determinants and health outcomes, enabling it to identify opportunities for eliminating health inequities across socioeconomic and demographic subpopulations. The OHE plans to use community-based participatory research to inform and support the design, development, implementation, and evaluation of health equity programs. Mechanisms for doing so have evolved. Historically, DC has collected and analyzed data primarily across the District of Columbia's eight wards. However, recognizing that the ward-based analysis misses more granular disparities, the OHE has started evaluating data by statistical neighborhoods based on census tracts. This analysis will provide the baseline for a planned inaugural health equity report.

Another major OHE strategy is demonstrating health equity practice change. As such, it is developing and implementing initiatives that have the potential to improve population health generally and promote health-enhancing opportunities, especially among vulnerable populations. For instance, the OHE worked with other District agencies and community partners on a Safer Stronger Advisory Committee to prevent violence using a public health approach.[8] The OHE also worked with other District agencies, community residents and developers on the Buzzard Point Community Health and Safety Study,[9] an assessment of potential health and safety issues facing Buzzard Point, a residential community within the city's southwestern quadrant.

8 Government of the District of Columbia (August 2015). Safer Stronger DC. Available at the "Executive Office of the Mayor" website. Last accessed: 1/24/18

9 District of Columbia Department of Health, Office of Health Equity (August 2016). Buzzard Point Community Health and Safety Study (CHASS). Available on the DOH website. Last Accessed: 3/27/2017.

### Partnerships

| | |
|---|---|
| Primary collaborators | • All five DOH Administrations—CPPE; CHA; HAHSTA; HEPRA; HRLA<br>• District of Columbia Department of Energy and Environment<br>• District of Columbia Department of Transportation<br>• District of Columbia Office of Planning<br>• Office of Deputy Mayor for Planning and Economic Development<br>• Office of the City Administrator<br>• Office of the Chief Medical Examiner<br>• District of Columbia Housing Authority<br>• DC Healthy Communities Collaborative<br>• Kaiser Permanente<br>• Advisory Neighborhood Commission 6D<br>• Empower DC<br>• Breathe DC<br>• District of Columbia Chamber of Commerce<br>• George Washington University<br>• Georgetown University<br>• Howard University<br>• Office of the State Superintendent for Education (OSSE) |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

The OHE works with many private, governmental, and nongovernmental organizations to achieve its overarching goal. For example, it informally partnered with the following District of Columbia agencies to address the brownfield site (i.e., a potentially contaminated property) that was ultimately redeveloped to house the new DC United Soccer Stadium: the Department of Energy and Environment, the Office of Deputy Mayor for Planning and Economic Development, the Office of Planning, the Department of Transportation, the Office of the City Administrator, and the District of Columbia Housing Authority. After analyzing health outcome data by census tract in the nearby residential neighborhoods, the OHE found increased rates for some diseases, together with significant socioeconomic disparities in risk and protective factors. It published these findings in a report, accompanied by recommendations, to protect community residents from adverse health effects, such as from dust and neighborhood quality of life impacts during construction.[10]

In another partnership example, the Rockefeller Foundation recently inducted the District of Columbia into a global network of "100 Resilient Cities."[11] The OHE has collaborated with the Office of the City Administrator to incorporate health and equity considerations in the overarching strategy, and with the DC Office of Planning to add a "resilience element" promoting health and equity considerations within the District of Columbia's Comprehensive Plan update, which will guide future development in the city.[12]

The OHE also works in partnership with the District of Columbia Department of Transportation, together with DOH Administrations, Center for Policy Planning and Evaluation (CPPE), and the Health Emergency Preparedness and Response Administration (HEPRA), on the "Vision Zero" Initiative. This effort seeks to attain zero fatalities and serious injuries to residents and visitors on DC streets. The CPPE's data analysis found that the city's serious or fatal injuries predominately involved racial or ethnic minorities, particularly African Americans, and in many cases involved children or older adults.[13]

In addition, the OHE works with DOH's Health Emergency Preparedness and Response Administration (HEPRA) to develop a trauma registry that engages local hospitals and trauma centers as partners. This registry tracks all trauma patients entering emergency rooms from trauma centers. Its initial goal was to track related serious injuries and fatalities, but the collaboration has enabled enhanced communication between the DOH, trauma centers, and other agencies that will enable a more robust registry that tracks additional detail (e.g., cause of injury and ambulatory transports).

10 Ibid.

11 The Rockefeller Foundation. 100 Resilient Cities. Website last accessed: 3/27/2017.

12 District of Columbia Office of Planning. Resilience. Available at the Office of Planning's website. Last accessed: 3/27/2017.

13 Government of the District of Columbia (December 2015). A Plan of Action, Vision Zero, Safe Streets for Washington, D.C. Available at the "DC Vision Zero" website. Last accessed: 3/27/2017.

The OHE also collaborated with the Office of the Chief Medical Examiner (OCME) on the Safer Stronger Advisory Committee, co-chaired by DOH and OCME directors. Following a spike in violence in the summer of 2015, the DOH took the lead in engaging the city in discussion of a public health approach to violence by gathering a 31-member public-private committee with representatives from social services, economic development, community organizations and courts. The committee made 55 multi-sectorial recommendations to prevent violence in a published report that was distributed to all deputy mayors.[14]

Another OHE collaboration is with the DC Healthy Communities Collaborative, which includes four hospitals (Providence Health System, Howard University Hospital, Children's National Health System, and Sibley Memorial Hospital), four community health centers (Community of Hope, Bread for the City, Mary's Center, and Unity Health Care), and two associations (DC Primary Care Association and DC Hospital Association). Under the Affordable Care Act, nonprofit health systems submit Community Benefit Plans every 3 years to maintain their IRS nonprofit status. Part of these requirements includes completing a community health needs assessment (CHNA) and improvement plan (CHIP). Through collaboration, the OHE promotes the alignment of the DC Healthy Communities Collaborative CHNA and CHIP with the strategic goals and priorities of *DC Healthy People 2020* (DOH's shared community agenda). Working towards a more formal partnership is envisioned in the medium term, which would leverage DOH local data in the Collaboration's CHNA process.[15]

Academic partnerships are another important DOH and OHE strategy. The OHE informally collaborates and consults with local universities, including Georgetown University, George Washington University, and Howard University. Indeed, OHE staff have given lectures and taught classes in these institutions, and academic staff from these schools participate in DOH and OHE activities.

Community-wide strategic engagement and information sharing are another part of the OHE's strategies for achieving health equity. For example, it has attended and presented to the DC Chamber of Commerce to inform Chamber committees and members about their role within a multi-sector "health in all policies" framework for improving community health and promoting health equity. This approach was presented by the DOH director to the DC Chamber of Commerce's committee on health.

## Funding

| | |
|---|---|
| Annual budget (FY 2017) of state/territorial minority health entity (SMHE) across all income sources | $1,100,000 |
| Annual budget (FY 2017) of SMHE from state/territorial government | $1,100,000 |
| Largest funding source | District of Columbia government |
| Anticipated changes to budget | None |

The total FY 2015 funding for the OHE was zero dollars, because it had not been formally launched. In FY 2016, the OHE's budget was $600,000. In FY 2017, the OHE's budget was $1,100,000. The District of Columbia fully funds the OHE. The OHE does not fund nongovernment organizations. The OHE does not anticipate funding changes in the next few years.

14 Government of the District of Columbia Department of Health (June 2016). Safer, Stronger DC Advisory Committee Final Report. Available at the DOH website. Last accessed: 3/28/2017.

15 District of Columbia Healthy Communities Collaborative (June 2016). District of Columbia Community Health Needs Assessment. Available at the "DC Health Matters" website. Last accessed: 3/28/2017.

# District of Columbia

## District of Columbia Data

| Total Population[a]: 681,170 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 10.9 | 89.1 | 40.9 | 47.2 | 0.1 | 3.9 | 7.9 | 100.0 | NA |
| Percent of population medically uninsured[a] | 11.3 | 3.2 | 2.1 | 4.7 | 0.0 | 2.0 | 11.6 | 4.1 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 14.0 | SP | 13.6 | SP | SP | NC | 8.8 | 5.9 |
| Age-adjusted mortality rate[b] | 412.6 | 779.7 | 422.3 | 1040.1 | SP | 356.5 | NC | 766.0 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 21.4 | 14.5 | 11.4 | 17.2 | SP | 19.8 | 20.7 | 15.1 | 13.6 |
| Percent with diabetes[c] | 3.0 | 8.2 | 2.5 | 14.1 | SP | 2.0 | 3.9 | 7.7 | 10.8 |
| Percent with heart disease[c] | 0.3 | 2.6 | 1.6 | 3.7 | SP | 0.0 | 1.0 | 2.4 | 4.3 |
| HIV rate[d] | 1954.1 | NC | 1098.5 | 4113.7 | 1018.8 | 306.7** | 4411.4 | 2590.2 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 71.4 | 80.0 | 69.2 | 89.5 | SP | 74.2 | 75.0 | 78.9 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 74.2 | 76.7 | 80.5 | 73.0 | SP | 74.4 | 74.9 | 76.6 | 66.5 |
| Percent received flu vaccine[c] | 32.6 | 37.7 | 47.0 | 28.8 | SP | 37.5 | 29.2 | 37.0 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

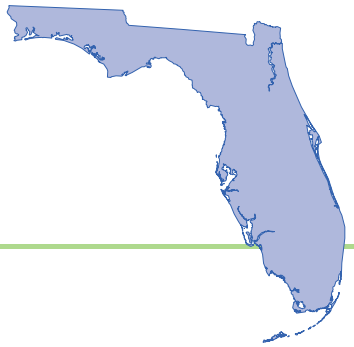
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 306.7 per 100,000 population (73 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 2730.4 per 100,000 population (8 cases).

# Florida



## Introduction to Florida's Health Equity Activities

Per Florida's Community Health Assessment Resource Tool Set, Florida had an estimated 2016 population of 20,231,092. Hispanics/Latinos are the largest racial-ethnic minority population (25 percent), followed by Blacks/African Americans (16 percent), Asian Americans and NHOPI (3 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 5 percent of the population.[1] Approximately 5,991,000 Florida residents live within a primary care health professional shortage area.[2]

In 2004, the Florida State Legislature established the Office of Minority Health within the Florida Department of Health (DOH). The name was changed to the Office of Minority Health and Health Equity (OMHHE) on July 1, 2016.[3]

### Florida Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Minority Health and Health Equity |
| Strategic plan in place to address minority health or health equity | Yes, health equity is integrated into all strategic plans of the Florida Department of Health. |
| Date strategic plan was last updated | Strategic plans are updated quarterly and annually. |
| Assessment plan in place to measure progress toward reducing health disparities | Within each strategic plan, objectives are specified. |
| Key strategies used to achieve health equity | • Diabetes self-management programming for African American and Hispanic communities<br>• HIV prevention and intervention in minority communities<br>• Health in All Policies initiative<br>• Healthiest Weight Initiative<br>• Chronic Disease Management<br>Florida statute mandates 10 priority areas that are addressed by the OMHHE. These priority areas include: Cancer, Diabetes, Cardiovascular Disease, Sickle Cell Disease, Infant and Maternal Mortality, Dental Health, Lupus, Adult and Child Immunizations, Social Determinants of Health, HIV/AIDS |

## Organizational Structure

The Florida legislators created the Senior Health Equity Officer position, which reports to the deputy secretary for health, who reports to the state surgeon general. A group of program staff and local health department directors comprise the Health Equity Program Council, which serves in an advisory role to the OMHHE. Members of the Health Equity Program Council champion health equity and implement activities within their respective communities.

The OMHHE has six full-time staff who are dedicated to minority health and health equity activities. Staff include the Senior Health Equity Officer, The Closing the Gap Grant Administrator, two mid-level staff who are responsible for contract management and event coordination, and two administrative support staff. The OMHHE anticipates that additional staff will join the office, but details are unknown at this time.

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 Florida DOH, Minority Health and Health Equity website. Last accessed 7/20/17

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Office of Minority Health and Health Equity is within the Office of the Deputy Secretary for Health. |
| SMHE staffing (full-time equivalents) | 6 |
| Advisory committee or panel | Health Equity Program Council |

## Program Goals and Activities

Although the OMHHE does not have a strategic plan focusing specifically on minority health or health disparity elimination, all DOH strategic plans promote health equity and health equity processes are embedded in the plans and strategies of all bureaus and divisions at the Florida Department of Health. Promoting health equity in all public health activities was a guiding principle for the DOH while developing its latest strategic plan. That document, the *Agency Strategic Plan 2016–2018*, includes strategies and objectives to address five strategic priorities and reach identified goals, including the strategy to "eliminate racial disparity in infant mortality."[4] In addition, the DOH is working on an update of the Florida State Health Improvement Plan to cover the period of 2017–2021.[5]

In Florida, minority health and health equity priorities are set through executive and legislative mandate. Available data and state health assessments aid the DOH in decision-making about priorities. Nongovernmental stakeholders are also involved in the priority-setting process. A State Health Improvement Plan Steering Committee is responsible for identifying priorities as part of the process for updating the plan.[6]

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Florida Department of Health | DOH |
| Office of Minority Health and Health Equity | OMHHE |

To improve minority health and reduce disparities, the OMHHE partners with local health organizations to provide diabetes self-management classes for African American and Hispanic communities. The DOH Division of Disease Control and Health Protection supports minority health by providing HIV prevention and intervention services in minority communities. Additionally, the HIV Prevention Program promotes HIV prevention among minority communities through a statewide media campaign that includes advertising, social media, and outreach events.[7] Statewide initiatives, such as Healthiest Weight Florida, promote health among all Floridians, including racial and ethnic minority populations.

In Hillsborough and Pinellas Counties, the DOH is working on a Health in all Policies strategy to encourage consideration of health in policies across different sectors in the county.[8] To advance Health in All Policies, local health department staff create recommendations and share with stakeholder and policymakers and advocate for inclusion of health in the policymaking process.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Franklin County Public Health<br>• Gulf County Health Department<br>• Hebni Nutrition Consultants<br>• Metropolitan Charities<br>• Mother Care Network<br>• Sickle Cell Foundation<br>• Latino Salud<br>• Caridad |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

The OMHHE partners with a range of organizations to advance minority health and health equity in Florida. The OMHHE collaborates with Metropolitan Charities on HIV prevention activities, including interventions, testing, and outreach to African American/Black and Hispanic youth ages 13–19. Hebni Nutrition Consultants, a community-based, nonprofit organization partners with the OMHHE to promote heathy eating

4 Florida Department of Health: Agency Strategic Plan 2016-2018. Available on the Florida DOH website. Last accessed 7/20/17.
5 Florida Department of Health: State Health Improvement Plan (SHIP). Available on the Florida DOH website. Last accessed 7/20/17.
6 Ibid.
7 Florida DOH, HIV/AIDS Section website. Last accessed 7/20/17.
8 Florida DOH in Hillsborough County Health in All Policies. Available on the Florida DOH website. Last accessed 7/20/17.

among diverse populations. Through this partnership, Hebni Nutrition Consultants launched Fresh Stop, a mobile farmers market to improve access to fresh fruits and vegetables for vulnerable populations in Central Florida.[9] Additionally, the OMHHE and Hebni Nutrition Consultants have worked on expanding Project Oasis, a program aimed at reducing the risk of diabetes by promoting consumption of fruits and vegetables.

Other significant nongovernmental partner organizations include the Sickle Cell Foundation and the Mother Care Network. The OMHHE contracts with the Sickle Cell Foundation to provide education, screening, case management, and support services for individuals with sickle cell disease or sickle cell trait and affected families in Orange, Seminole, and Osceola Counties (i.e., the Tri County area). Mother Care Network and the OMHHE work together on a community-based program aimed at improving health outcomes for individuals with type 2 diabetes and cardiovascular disease in Gadsden County.

In addition, through the Closing the Gap grant the OMHHE partners with the University of Florida College of Medicine's Mobile Outreach Clinic, which both facilitates training and provide services to include low-income and underserved communities in and around Alachua County.[10] Also supported by the OMHHE's Reducing Racial and Ethnic Health Disparities "Closing the Gap" grant, Gulf and Franklin County Health Departments deliver healthy cooking demonstrations in grocery stores and facilitate healthy eating curriculum in faith-based organizations. This work aligns with other initiatives, including Healthiest Weight Florida and Community Health Improvement Plans.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $2,800,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $2,800,000 |
| Largest funding source | State |
| Anticipated changes to budget | No |

The FY 2015 budget for the OMHHE was $2,800,000, which includes state general revenue and has been stable at this level for 3 years. There were no additional sources of funding for the OMHHE in FY 2015. The OMHHE does not anticipate changes in the levels and sources of funding.

9 Information is available on the Fresh Stop website. Last accessed 7/20/17.

10 Information is available on the University of Florida, College of Medicine's Mobile Outreach Clinic website. Last accessed 7/20/17.

# Florida

## Florida State Data

| Total Population[a]: 20,612,439 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 24.9 | 75.1 | 75.5 | 16.1 | 0.3 | 2.8 | 5.4 | 100.0 | NA |
| Percent of population medically uninsured[a] | 19.7 | 10.8 | 12.0 | 15.8 | 24.7 | 11.4 | 19.0 | 13.0 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 4.4 | 6.9 | 4.7 | 10.8 | SP | 6.2 | NC | 6.2 | 5.9 |
| Age-adjusted mortality rate[b] | 517.0 | 705.8 | 663.1 | 742.3 | 318.1 | 331.5 | NC | 666.6 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 11.9 | 10.8 | 10.9 | 11.7 | 14.3 | 9.0 | 10.6 | 11.0 | 13.6 |
| Percent with diabetes[c] | 11.0 | 12.1 | 11.4 | 14.8 | 9.1 | 10.9 | 10.6 | 11.8 | 10.8 |
| Percent with heart disease[c] | 2.9 | 5.2 | 5.3 | 3.0 | 4.8 | 4.0 | 3.5 | 4.7 | 4.3 |
| HIV rate[d] | 595.2 | NC | 302.4 | 1929.8 | 126.7 | 102.4** | 1112.7 | 615.2 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 74.1 | 78.6 | 77.9 | 80.7 | 64.7 | 76.6 | 71.9 | 77.8 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 61.0 | 65.1 | 66.1 | 58.9 | 65.2 | 70.5 | 56.1 | 64.4 | 66.5 |
| Percent received flu vaccine[c] | 27.5 | 37.3 | 37.5 | 27.1 | 21.8 | 35.8 | 28.7 | 35.1 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

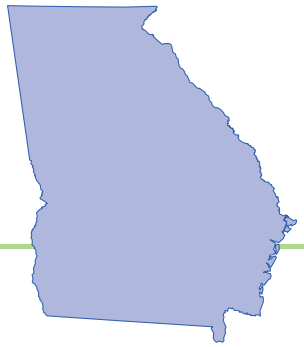
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 102.4 per 100,000 population (480 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 375.6 per 100,000 population (40 cases).

# Georgia



## Introduction to Georgia's Health Equity Activities

Georgia had an estimated 2016 population of 10,310,000. Blacks/African Americans are the largest racial-ethnic minority population (32 percent), followed by Hispanics/Latinos (9 percent), Asian Americans and NHOPI (4 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 5 percent of the population.[1] Approximately 3,239,000 Georgia residents live within a primary care health professional shortage area.[2]

The state is often thought of as consisting of "two Georgias": the sparsely-populated areas—where health care inaccessibility is a significant issue, and the greater Atlanta metropolitan area. Given the range of needs facing both rural and urban Georgians, the Georgia Department of Public Health conducted focus groups and listening sessions throughout the state to help inform its efforts to set strategic priorities. The information and feedback was used to develop the State Health Assessment (SHA). The input gathered in the SHA identified maternal and child health, chronic disease, and access to care as key areas of concern.

According to the Georgia SHA, various populations face significant health disparities across different health outcome areas. For example, African American women are more likely than White women to be diagnosed with breast cancer at later stages, regardless of insurance status, and more likely to die of breast cancer in Georgia. Low income children are more likely to be overweight or obese. White males in rural communities are more likely to use tobacco products than other population groups in Georgia. Partners, stakeholders, and community members from throughout the state that participated in the SHA community forums felt that health equity was an important consideration in the SHA priority areas selected as well as an important framework for action on many of the priority areas.

The Georgia Department of Public Health (GDPH) seeks to improve the health of all Georgians by integrating the promotion of health equity into all statewide public health programs and services and into the organizational culture of the department. As such, the GDPH continues to enhance and grow its cross-sectional health equity and minority health focus throughout the organization. Because minority health and health equity activities are integrated into all departmental programs, the Office of the Chief of Staff manages oversight of health equity initiatives.

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

# Georgia

### Georgia Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Minority Health |
| Strategic plan in place to address minority health or health equity | No minority health strategic plan has been developed since 2014. The 2016–2021 Georgia State Health Improvement Plan (SHIP) incorporates themes of health disparities and health equity through the identification of social determinants of health relevant to specific strategies and activities. Health equity will also be included within the department's strategic plan. |
| Date strategic plan was last updated | N/A |
| Assessment plan in place to measure progress toward reducing health disparities | SHIP performance measures related to health disparities are monitored and tracked on a regular basis. Programs also monitor progress in association with routine grantee reporting to funders. For ongoing assessment, future plans include tracking and monitoring progress of health equity measures within the agency-wide performance management system. |
| Key strategies used to achieve health equity | • Ensure departmental divisions, sections, and programs use a comprehensive set of strategies including community engagement, data collection and analysis, evaluation, and policy development to advance health equity, reduce health disparities, and improve minority health.<br>• Assist staff in gaining a comprehensive understanding of identifying and addressing health equity issues by ensuring the appropriate and relevant workforce development and trainings are provided.<br>• Establish and enhance multi-sector state and local partnerships to address health inequities |

## Organizational Structure

Some GDPH programs have staff with dedicated time towards health equity and minority health tasks and responsibilities. This includes the GDPH director of the Chronic Disease Prevention Section, who dedicates 5 percent time to minority health and health equity initiatives; a Food and Language Nutrition Program manager serving 100 percent time on minority health and health equity initiatives; and a food and language nutrition evaluator, who dedicates 25 percent time to minority health and health equity initiatives.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/ territorial government | Health equity and minority health activities and strategies are embedded within programs throughout the department and are coordinated collectively through the Office of the Chief of Staff. |
| SMHE staffing (full-time equivalents) | 1.5 |
| Advisory committee or panel | Currently, the GDPH is in the process of developing an internal health equity committee of representatives from the agency's internal programs. The GDPH also has future plans to convene a workgroup of internal and external partners focused on health equity that will meet at least twice per year and will advise the GDPH on matters related to minority health, health disparities and opportunities to promote health equity. |

## Program Goals and Activities

The GDPH is in the process of developing a health equity action plan to capture and track the various health equity activities throughout the programs. Additionally, the GDPH is developing a departmental health indicators list to assist in developing program-specific health equity measures and support programs' efforts to assess health disparities and minority health. Below are some of the departmental health equity and minority health-related goals and activities.

In seeking National Public Health Accreditation, the GDPH engaged in quality improvement efforts that clarified the department's plans for ensuring health equity, reducing health disparities, and meeting other objectives including those outlined in the SHIP. The SHIP, which is publicly available on the GDPH website, addresses health equity and health disparities issues, particularly around maternal and child health, chronic

disease, and access to care. GDPH programs collaborate with partners throughout the state to achieve the SHIP goals and objectives. One of the health equity activities noted in the SHIP is to provide transportation vouchers for children and youth with special health care needs (CYSHCN) to access needed services as well as cover liability insurance for church vans to provide transportation to services for CYSHCN. Another health equity-related SHIP strategy is to reduce disparities in cancer morbidity and mortality.

The GDPH divisions, sections, and programs are required to collaborate with the Division of Workforce Management to ensure workforce development and training around the definitions of health equity and health disparities, and strategies to promote health equity, improve minority health, and reduce health disparities in Georgia. Trainings include an annual Cultural Competency training and Health Equity trainings offered internally and by external partners. The GDPH has worked with Region IV Public Health Training Center to offer health equity and cultural competency trainings to departmental staff. The GDPH is also in the process of developing a health equity training specific to the department and the unique health disparity priorities in Georgia.

The GDPH telehealth program seeks to achieve the Healthy People 2020 goal concerning the use of health communication strategies and health information technology to improve population health outcomes, improve health care quality, and achieve health equity. Additionally, the GDPH connects heavily to the other several related objectives that support shared decision-making between patients and providers. The telehealth movement helps this shared decision-making and fundamentally changes the relationship between patients and providers to an interaction that supports an informed, bilateral conversation to improve health. Other health equity-related Healthy People 2020 objectives that are utilized within the GDPH telehealth program include goals to deliver reliable and actionable health information, to connect with culturally diverse and hard-to-reach populations, and provide sound principles in the design of programs and interventions that result in healthier behaviors.

The GDPH's Office of Emergency Preparedness and Office of State Refugee Health recognized cultural and language barriers as factors contributing to health inequity among the refugee population, specifically, as it relates to refugees' knowledge and needs regarding public health emergency preparedness. To address this issue, the state office partnered with DeKalb County Health Department and the Georgia Coalition of Refugee stakeholders to initiate a pilot program to build resilience among the refugee community in DeKalb County, Georgia. As a result of the success of the pilot, the group decided to continue program community preparedness/education, program public information/communication, and expansion of the program for the refugee population.

Georgia reports disparities in oral health similar to the national findings. In Georgia the highest percentage of tooth decay is reported among non-Hispanic Black children (24.7 percent) while the lowest was reported among non-Hispanic White children (13.2 percent). The percentage among Hispanic children (23.7 percent) was very similar to non-Hispanic Blacks. There were disparities by race/ethnicity. Parents of Hispanic children in Georgia reported the lowest percentage of preventive dental visits (69.6 percent) compared to both the national estimate for Hispanic children (73.9 percent) and peers of other races in Georgia. Within Georgia, the most sizable ethnic disparity for childhood dental visits was in Hispanic children ages 1 to 17 years old in 2011/2012. Only 69.6 percent of Hispanic children had one or more preventive dental care visits (check-ups and cleanings) compared to 73.9 percent of Hispanic children nationally and 77.5 percent of non-Hispanic White children in Georgia.

To address these health disparities, one of the program's strategies is to promote oral health among low-income Hispanic mothers and children in Georgia. To implement this strategy, the Oral Health Education Initiative for low-income Hispanic children and adolescents will revise its education to reduce barriers in language and cultural differences among Hispanic populations. The program partners with the Georgia Department of Education and the GDPH local public health districts to complete the necessary activities.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Georgia Department of Public Health | GDPH |
| State Health Assessment | SHA |
| State Health Improvement Plan | SHIP |
| Children and youth with special health care needs | CYSHCN |

Another GDPH Oral Health program strategy is to develop one oral health resource database for CYSHCN. This is accomplished by identifying data sources and collecting data to develop a special needs dental access database with location of practices serving special needs children and adults/special services offered, such as general anesthesia, orthodontics, insurance accepted, and other specialties. The Oral Health program partners with the following entities to achieve this goal: Georgia Dental Association, Georgia Association for Primary Care, and Federally Qualified Community Health Centers.

The GDPH's HIV Program seeks to increase the provision of integrated services to reduce social determinants of health and reduce HIV-related health disparities. In doing so, the program utilizes the U.S. Department of Health and Human Services, Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care to ensure that efforts to address HIV prevention, care, and treatment service goals are infused with cultural competency and cultural sensitivity.

Additionally, one of the strategies in the Georgia Integrated HIV Prevention and Care Plan is to provide HIV resources in communities/ZIP codes with the highest concentration of health disparities. Related activites include:

- Identifying communities/ZIP codes with highest concentration of health disparities
- Assessing disparities in communities/ZIP codes where HIV is most heavily concentrated to identify existing HIV services well an HIV resource gaps and barriers
- Based on assessment, establishing the health resources to be provided through mobile clinic system
- Developing partnerships with existing HIV service providers in targeted areas
- Developing and implementing communications plan to educate community and existing providers about the availability of mobile clinic HIV services and how to access these services
- Implementing system of at least two mobile clinics to serve identified ZIP codes with highest concentrations of health disparities and improve access to care
- Integrating HIV services in existing clinical practices.

The Georgia Tobacco Use Prevention Program leads the GDPH's efforts to implement the Georgia SHIP strategy to identify and eliminate tobacco-related disparities among population groups. To do this, the program and its partners identify and direct interventions toward populations disproportionately impacted by tobacco use. Currently, the following population groups experience the highest burden of tobacco use in Georgia:

- Adult males (22 percent)
- Adults with an estimated income below federal poverty level (31.7 percent)
- Adults with less than a high school diploma (29 percent)
- Adults who are Medicaid recipients (26 percent).

Another activity from this strategy is to expand the number of partners from all sectors and racial and ethnic groups, as well as age groups, engaged in tobacco control initiatives. Current partners include: Local Public Health Departments, Georgia Department of Education, Parent Teacher Association, Georgia Parks and Recreation Association, University System of Georgia and the Technical College System of Georgia, Historically Black Colleges and Universities, Association of City and County Governments, American Cancer Society, American Lung Association, American Heart Association, Georgia Public Health Association, and the Georgia Tobacco Statewide Coalition.

Staff within the GDPH's Division of Health Protection, Chronic Disease Prevention Section work on several health equity initiatives. For example, one project seeks to improve outcomes through an integrated food and language nutrition program targeting early childcare educators and families of dual-language learners in three small, at-risk cities (Dalton, Valdosta, and Clarkston). The project includes trainings with early childhood education professionals on strategies to educate and partner with families around increasing healthy eating, improving physical activity, and supporting language acquisition. Through this project, section staff are developing profiles for the three communities that assess key outcomes (i.e., nutrition adequacy, physical activity, school readiness, and academic performance), and documenting observed racial and ethnic disparities.

Through the Office of Minority Health's State Partnership Initiative grant, the GDPH partners with state and local partners to collaborate on efforts to improve

outcomes and eliminate identified disparities. Georgia Early Education Alliance for Ready Students conducted community listening sessions in the three target communities to learn more about current strategies and barriers early childhood educators and families have to providing a nutrition- and language-rich environment for children under 5. Emory University's Nell Hodgson Woodruff School of Nursing, the Atlanta Speech School, and HealthMPowers developed the training and toolkit for early childhood educators based on their expertise and community listening sessions findings. The Friends of Refugees Mommy & Me Family Literacy Program provided expertise in developing the training materials and a pilot peer-to-peer home visiting component for young children living in refugee families. The GDPH also partnered closely with Georgia Department of Early Care and Learning to assure fidelity of the intervention to early care quality-rated standards and to assist in connecting with local early care communities in the three target cities.

### Partnerships

| | | |
|---|---|---|
| Primary collaborators | • Atlanta Speech School<br>• Emory University, including the School of Nursing<br>• Friends of Refugees – Mommy & Me Family Literacy Program<br>• Georgia Department of Early Care and Learning<br>• Georgia Early Education Alliance for Ready Students<br>• HealthMPowers<br>• DeKalb County Board of Health<br>• GDPH Emergency Preparedness<br>• Region IV Public Health Training Center<br>• Georgia Coalition of Refugee<br>• MARTA; Metropolitan Atlanta Rapid Transit Authority<br>• Local Faith-based organizations<br>• Emergency Medical Services | • Local Public Health Departments<br>• Georgia Department of Education<br>• Parent Teacher Association<br>• Georgia Parks and Recreation Association<br>• University System of Georgia and the Technical College System of Georgia<br>• Historically Black Colleges and Universities<br>• Association of City and County Governments<br>• American Cancer Society<br>• American Lung Association<br>• American Heart Association<br>• Georgia Public Health Association<br>• Georgia Tobacco Statewide Coalition<br>• Georgia Dental Association<br>• Georgia Association for Primary Care<br>• Federally Qualified Community Health Centers |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. | |

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $2,800,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $2,800,000 |
| Largest funding source | State |
| Anticipated changes to budget | No |

The total FY 2015 budget focused solely on health equity and minority health was $200,000, funded exclusively by the SPI grant. This amount reflects the only grant solely designated for health equity and minority health efforts. The GDPH has a total of 52 grants which have a health equity and/or minority health component. FY 2015–2016 was the first year of the 5-year SPI grant. The GDPH provided funding to several other governmental or nongovernmental entities for health disparities or health equity activities in FY 2015 as part of the SPI grant, including the Atlanta Speech School, the Emory University School of Nursing, Friends of Refugees Mommy & Me Family Literacy Program, the Georgia Early Education Alliance for Ready Students, and HealthMPowers.

It is hoped that funding sources will increase as organization's health equity efforts continue to grow.

# Georgia

## Georgia State Data

| Total Population[a]: 10,310,371 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 9.3 | 90.7 | 58.8 | 31.6 | 0.4 | 3.9 | 5.3 | 100.0 | NA |
| Percent of population medically uninsured[a] | 32.7 | 11.5 | 12.2 | 14.0 | 31.3 | 11.7 | 23.8 | 13.4 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 5.8 | 8.1 | 5.3 | 12.4 | SP | 3.1 | NC | 7.8 | 5.9 |
| Age-adjusted mortality rate[b] | 342.5 | 819.9 | 792.4 | 859.3 | 158.4 | 393.6 | NC | 800.4 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 8.1 | 13.8 | 13.5 | 14.6 | 19.9 | 4.7 | 11.1 | 13.5 | 13.6 |
| Percent with diabetes[c] | 9.1 | 12.4 | 12.5 | 13.0 | 11.8 | 4.2 | 11.3 | 12.3 | 10.8 |
| Percent with heart disease[c] | 2.2 | 4.8 | 5.5 | 4.0 | 2.0 | 0.0 | 3.2 | 4.7 | 4.3 |
| HIV rate[d] | 488.8 | NC | 203.0 | 1323.5 | 100.9 | 64.0** | 2219.3 | 588.0 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 62.8 | 75.6 | 73.2 | 80.7 | 53.6 | 71.6 | 62.8 | 74.8 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 61.2 | 64.1 | 66.2 | 59.6 | 46.4 | 69.0 | 59.1 | 63.8 | 66.5 |
| Percent received flu vaccine[c] | 28.9 | 35.7 | 41.0 | 27.6 | 40.2 | 25.5 | 25.1 | 35.8 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

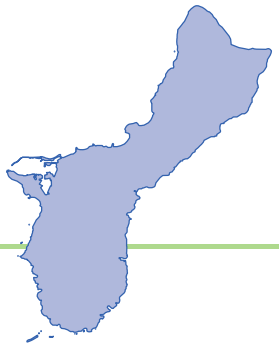
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 64.0 per 100,000 population (210 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 282.6 per 100,000 population (14 cases).

# Guam



## Introduction to Guam's Health Equity Activities

Guam, the largest island in the Mariana Islands, located in the western North Pacific Ocean, is an unincorporated U.S. Territory with a land area of 210 square miles. It had an estimated 2010 population of 159,000. Native Hawaiians and Other Pacific Islanders (NHOPI) are the largest minority population (49 percent), followed by Asians (34 percent). Persons self-identifying as multiracial comprise 9 percent of the population.[1]

A gubernatorial executive order created the Guam Office of Minority Health (OMH) in 2010. Originally named the State Office of Minority Health, the Guam OMH strives "to promote the elimination of health disparities in minority communities specifically to reduce health disparities in cancer, obesity and overweight."[2]

### Guam Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Guam Office of Minority Health |
| Strategic plan in place to address minority health or health equity | The Guam Office of Minority Health was involved in the planning for Guam's Non-Communicable Disease Strategic Plan (2014–2018).<br>A comprehensive strategic plan for the Department of Public Health and Social Services is being developed |
| Date strategic plan was last updated | 2013 |
| Assessment plan in place to measure progress toward reducing health disparities | • Evaluation plan included in the Non-Communicable Disease Strategic Plan (2014-2018).<br>• The Guam Office of Minority Health partners with the U.S. Office of Minority Health Resource Center and local consultants who assist with measurement |
| Key strategies used to achieve health equity | • Community Garden Project<br>• Salt Reduction Initiative<br>• Breastfeeding Promotion<br>• Worksite Wellness Program<br>• Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) trainings<br>• Guam Language Access Plan |

## Organizational Structure

Located within the Division of Public Health and Social Services' Bureau of Community Health Services, the Guam OMH is responsible for administering non-communicable disease control and health promotion programs, as well as the federal Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System.[3] Other Department of Public Health and Social Services divisions include the Bureau of Communicable Disease Control, the Bureau of Family Health and Nursing Services, the Bureau of Nutrition Services, and the Bureau of Primary Care Services.

At this time, the Guam OMH has one full-time, mid-level staff member who is fully dedicated to working on minority health, health disparity, and health equity initiatives. The Health Services Administrator's primary department is the Department of Public Health and Social Services, but is responsible for BCHS operations and staff. This senior-level staff member, who is involved in all BCHS programs, can dedicate only approximately 10 percent time to working specifically on minority health initiatives. Volunteers, including unpaid interns from the University of Guam, help to support Guam OMH activities.

1 U.S. Census Bureau. 2010 Census Island Areas: 2010 Census Detailed Crosstabulations

2 Available on the Guam Office of Minority Health website. Last accessed 6/16/2016.

3 See Guam's DPHSS's Bureau of Community Health Services Webpage. Last accessed 1/13/2018.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Guam Office of Minority Health is located within the Bureau of Community Health Services, which is within the Department of Public Health and Social Services. |
| SMHE staffing (full-time equivalents) | 1 |
| Advisory committee or panel | None |

## Program Goals and Activities

The Guam OMH participated in planning efforts that led to the development of the Guam Non-Communicable Disease Strategic Plan: 2014-2018 ("Strategic Plan"),[4] which aims to reduce the prevalence of non-communicable diseases on the Island. It focuses both on improving health outcomes broadly and on using culturally relevant strategies to promote healthy behaviors (e.g., the *Live HEALTHY Guam!* media campaign). The Strategic Plan includes a comprehensive evaluation and assessment structure, complete with specific metrics to quantify all modifiable risk factors identified by the Plan's prevention strategies and objectives. Assistance with measurement issues related to minority health, health disparities, and health equity comes from the U.S. Office of Minority Health Resource Center. Local consultants also provide evaluation services for the Guam Department of Public Health and Social Services (DPHSS) and are active participants in developing and conducting evaluations in alignment with the Strategic Plan.

In 2017, the Guam DPHSS began developing a comprehensive division-wide Strategic Plan that will include strategies for addressing minority health and health equity. Within the division-wide Strategic Plan, the Guam OMH plans to announce a new name for the office—the Guam Office of Minority Health and Health Equity—to encompass its focus on reducing health disparities and achieving health equity.

The Guam OMH relies on several data sources to help inform priorities related to minority health, health disparities, and health equity. Two primary data sources are DPHSS client surveys and feedback from service providers. Client surveys, including those conducted at community outreach events, help the DPHSS identify community needs. The Guam OMH also reviews data from DPHSS client intake forms to inform its priorities. Service providers also offer feedback to improve access and care delivery, sharing success stories about caring for multicultural and multiethnic populations, providing feedback on barriers and challenges, and informing the Guam OMH when materials in particular service locations need to be translated into additional languages. Other Guam OMH partners include higher education institutions, the Guam Legislature, the U.S. Department of Veterans Affairs, local U.S. military facilities, the Archdiocese of Hagatna, Catholic Social Services, and other organizations to set priorities.

Language access remains a major priority of the Guam OMH. Other efforts to achieve health equity within the Island focus on prevention and chronic disease reduction, including efforts to improve healthy behaviors around weight management and tobacco use. Initiatives led by the Bureau of Community Health Services (BCHS) or the Guam DPHSS that address ethnic disparities in chronic disease treatment and prevention include a Community Garden Project, a Salt Reduction Initiative, Breastfeeding Promotion, a Worksite Wellness Program, and tobacco cessation services. Because of the high prevalence across the Island, these initiatives have been implemented throughout Guam. While the BCHS or the DPHSS lead these initiatives, the Guam OMH plays a key role in planning and implementation activities.

**Community Garden Project.** Primarily targeting single-family households, the Guam DPHSS, in partnership with the University of Guam, leads the Community Garden Project. Through this program, families receive gift cards to buy items and supplies for gardening and learn about growing fruits and vegetables at home. The Guam DPHSS is looking to expand this successful effort to nonprofit organizations and schools.

4 "Live Healthy Guam: Guam Non-Communicable Disease Strategic Plan 2014-2018." A collaborative effort by the Department of Public Health and Social Services and the Non-Communicable Disease Consortium. December 2013. Available on the Guam DPHSS website. Last accessed 1/13/2018.

# Guam

## Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Guam Department of Public Health and Social Services | DPHSS |
| Guam Office of Minority Health | Guam OMH |
| DPHSS's Bureau of Community Health Services | BCHS |

**Salt Reduction Initiative.** In partnership with the University of Hawaii, BCHS also established the Salt Reduction Initiative, which has enlisted 50 restaurants to voluntarily remove salt dispensers from tables and offer brochures highlighting the dangers of excessive salt consumption. The initiative, which has signed on an additional 25 restaurants to remove salt dispensers in 2017, also urges restaurant chefs to reduce salt content in prepared meals and to develop additional resources for the public.

**Breastfeeding Promotion.** A major milestone of the BCHS' breast feeding promotion efforts included the enactment of a law supporting women's right to breastfeed anywhere on the Island. Other efforts have sought to identify dedicated breastfeeding rooms in all government offices and have introduced a breastfeeding training certification program to ensure there are certified lactation specialists on Guam. The breastfeeding promotion activities seek to educate women about the health benefits of breastfeeding, eradicate inaccurate beliefs about the practice and, ultimately, to make breastfeeding a cultural norm. The BCHS partners with the Federal Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to promote breastfeeding and disseminate information to women of childbearing age.

**Worksite Wellness.** In response to a gubernatorial executive order, the BCHS implemented the Worksite Wellness Program[5] to reduce the incidence of cancer, obesity, and cardiovascular disease on the Island. Government of Guam employees can use 3 hours per work week to engage in a wide array of physical activities at their government workplace or at a wellness facility (e.g., aerobic dancing, swimming, dancing, weight training, martial arts, and yoga), as well as meditation and healthy cooking classes. The program also offers additional educational and wellness activities.

**Language Services.** The Guam OMH spearheads a range of language access services across the Island. For example, the DPHSS mandated that any Guam government employee in direct contact with a consumer or client take an 8-hour Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS) training course. The Guam OMH provides, on average, one training per month for approximately 100 people. Although the trainings are mandated only for Guam government employees, there has been interest in expanding the trainings to hospital personnel and other social service providers. In addition, the Guam OMH provides CLAS trainings for all Guam judiciary staff. The Guam Language Access Plan, also under the purview of the Guam OMH, operates in conjunction with "Culture and Language Access Service Partners," a coalition that aims to diminish language and culture barriers on Guam.[6] Culture and Language Access Service Partners includes representatives from the Guam judiciary, law enforcement, educators, the Guam DPHSS, nonprofit organizations, and other stakeholder groups.

## Partnerships

| | |
|---|---|
| Primary collaborators | • University of Guam<br>• Guam Legislature<br>• Guam judiciary<br>• Archdiocese of Hagatna<br>• Guam's Alternative Lifestyle Association<br>• Health Services of the Pacific |
| Contracts or memoranda of understanding with any partners | Yes, contracts are implemented for some partnerships (e.g., Guam's Alternative Lifestyle Association). |

Several organizations work closely with the Guam OMH to address health disparities. For example, the University of Guam partners with the Guam OMH on the Guam Cancer Registry, the Community Garden Project, tobacco cessation services, sexual health, and violence prevention. Governmental agencies also play a role. The Guam Legislature also provides support in advancing DPHSS initiatives, enacting policies and laws to promote healthier living. The Guam OMH

5 Government of Guam Worksite Wellness Steering Committee. "Government of Guam Worksite Wellness Program." Revised July 2012. Available on the Guam DPHSS website. Last accessed 1/13/2018.

6 Bernadine Racoma. "Coalition in Guam Wants to Break Language and Cultural Barriers through Translation." January 31, 2014. Day Translations. Available at the Day Translations website. Last accessed: 1/13/2018

works closely with the Island's judiciary to certify interpreters for court and health care settings, train interpreters, and provide compensation for certified translation services.

Two nonprofit organizations, the Archdiocese of Hagatna and Guam's Alternative Lifestyle Association, have become key partners with the Guam OMH. The Archdiocese publishes a weekly newspaper that regularly includes a column written by the Guam DPHSS focusing on diseases and prevention. Guam's Alternative Lifestyle Association, a community-based organization that exists to strengthen the quality of life for gay, lesbian, bisexual, and transgendered persons, worked in collaboration with Guam OMH in the development of the Non-Communicable Disease Strategic Plan. Guam OMH also partners with "Health Services of the Pacific," a private home health agency providing care to clients suffering from chronic and other conditions. Several Health Services of the Pacific employees are dually employed by the DPHSS and provide health education and chronic disease management support to bedbound clients.

## Funding

| | |
|---|---|
| Annualized budget (FY 2014) of state/territorial minority health entity (SMHE) across all income sources | $100,000 |
| Annual budget (FY 2014) of SMHE from state/territorial government | $100,000 |
| Largest funding source | Territorial government |
| Anticipated changes to budget in FY 2016 | No |

The total FY 2014 funding for the Guam OMH was $100,000. This funding level has been consistent for the past 3 years. Prior to receiving funding from the Territory of Guam, the Guam OMH received funding directly from the U.S. Office of Minority Health.

# Guam

## Guam Territory Data

| Total Population[a]: 159,358 | Race | | | | | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Pacific Islander | | | Asian | | | | | | | |
| | Chamorro | Chuukese | Other PI | Filipino | Korean | Other Asian | White | Multi-racial | Other | Territory Total | National Total |
| **Population Characteristics** | | | | | | | | | | | |
| Percent of state population[a] | 37.3 | 7.0 | 5.0 | 26.3 | 2.2 | 5.1 | 7.1 | 9.4 | 2.0 | 100.0 | NA |
| Percent of population medically uninsured[a] | 13.3 | 32.9 | 31.4 | 27.8 | 57.4 | 31.3 | 9.5 | 14.9 | 11.4 | 21.1 | 16.3[b] |

| Population Characteristics | Ethnicity | | Race | | | | Totals | |
|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | Asian American and NHOPI* | Multi-racial or Other | National Total | Other Asian |
| **Health Disparities** | | | | | | | | |
| Vital Statistics | | | | | | | | |
| Infant mortality rate[c] | NC | NC | NC | NC | NC | NC | 5.9 | 6.6 |
| Age-adjusted mortality rate[c] | NC | NC | NC | NC | NC | NC | 728.8 | 717.6 |
| Prevalence of Selected Chronic Diseases | | | | | | | | |
| Asthma[d] | 15.6 | 9.6 | 4.5 | SP | 10.1 | 11.1 | 13.6 | 14.1 |
| Diabetes[d] | 12.8 | 9.6 | 4.8 | SP | 11.1 | 8.1 | 10.8 | 10.8 |
| Heart disease[d] | 8.2 | 3.7 | 4.8 | SP | 3.5 | 5.3 | 4.3 | 3.8 |
| HIV[e] | SP | NC | SP | SP | SP | SP | 362.3 | 657.8 |
| Preventive Services | | | | | | | | |
| Routine check-up (past 12 months)[d] | 70.8 | 67.1 | 76.1 | SP | 66.8 | 64.1 | 67.1 | 72.2 |
| Oral health visit (past 12 months)[d] | 63.8 | 58.5 | 77.6 | SP | 58.7 | 49.9 | 58.6 | 66.5 |
| Flu vaccine[d] | 33.6 | 29.7 | 55.2 | SP | 28.1 | 23.6 | 29.6 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: U.S. Census Bureau. 2010 Census Island Areas: 2010 Census Detailed Crosstabulations.

b Source: U.S. Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States: 2010.

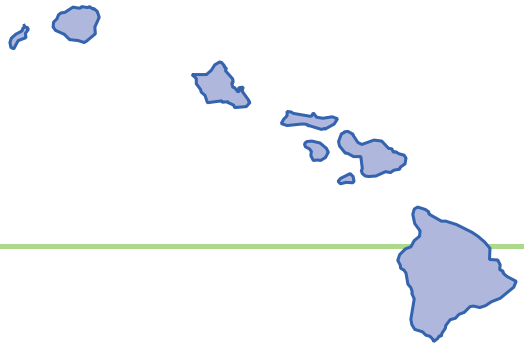
c Source: CDC National Vital Statistics Reports, Deaths: Final Data for 2015.

d Source: Behavioral Risk Factor Surveillance System, 2016.

e Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015.

*Native Hawaiian and Other Pacific Islander

# Hawaii



## Introduction to Hawaii's Health Equity Activities

Hawaii had an estimated 2016 population of 1,429,000. Asian Americans and NHOPI are the largest racial-ethnic minority population (48 percent), followed by Hispanics or Latinos (10 percent), Blacks or African Americans (2 percent), and American Indians/Alaska Natives (less than 1 percent). Multiracial or other minority racial groups comprise 25 percent of the population.[1] Approximately 184,000 Hawaii residents live within a primary care health professional shortage area.[2]

In the late 1980s, the Office of Hawaiian Health evolved to focus more broadly on health equity issues, and changed its name to the Office of Health Equity (OHE), with a specific focus on addressing health disparities across Hawaii. The OHE was unstaffed at the time of data collection, and the future direction of the OHE and responsibilities of OHE staff were under Hawaii Department of Health (HDH) review to ensure they are aligned with the mission of the OHE and the goals of the HDH. Despite the halt in OHE activity during this transition, the Chronic Disease Prevention and Health Promotion Division (CDPHPD) of the HDH is leading many initiatives to eliminate health disparities and achieve health equity.

### Hawaii Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | The Office of Health Equity was established to address health disparities in Hawaii, but it is currently unstaffed and its future direction is under review by the state. |
| Strategic plan in place to address minority health or health equity | A strategic plan specifically to address minority health or health equity is not available. However, comprehensive plans that take into account social determinants of health are included in the Hawaii Department of Health Strategic Plan |
| Date strategic plan was last updated | 2016 |
| Assessment plan in place to measure progress toward reducing health disparities | A formal plan to measure progress toward reducing health disparities is not available. However, a dashboard to track progress toward reaching the goals in the Hawaii Department of Health Strategic Plan is publicly available. |
| Key strategies used to achieve health equity | • Working with federally qualified health centers to improve care delivery<br>• Improving access to primary care and cancer screening<br>• Improving language access services<br>• Promoting physical activity<br>• Promoting Supplemental Nutrition Assistance Program education (SNAP-Ed)<br>• Promoting tobacco prevention and education program |

## Organizational Structure

The CDPHPD is housed within the Health Resources Administration of the HDH. While there is no advisory committee or panel present to advise the CDPHPD on minority health and health disparity issues, the Office of Affirmative Action serves as a resource while the Office of Health Equity remains unstaffed. In addition, the Language Access Advisory Council aids the Office of Language Access by providing guidance on language access laws, policies, and services.[3]

A number of staff from the CDPHPD spend at least some portion of their work day on

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 State of Hawaii, Office of Language Access. Meet the Council. Available at the Hawaii Department of Health website. Last accessed 01/30/2017.

minority health, health disparity, or health equity initiatives. Full-time staff include the Bilingual Health Education Aide program manager, an environmental change specialist, the SNAP-Ed coordinator, a school health coordinator, bilingual health aides, and Easy Access Project staff. At least 11 individuals spend time working on minority health, health disparity, and health equity activities. However, these activities are embedded in daily work activities for most staff in the HDH. No timeline had been established at the time of data collection for hiring dedicated OHE personnel.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Chronic Disease Prevention and Health Promotion Division is housed within the Hawaii Department of Health, Health Resources Administration. |
| SMHE staffing (full-time equivalents) | 11 |
| Advisory committee or panel | None |

## Program Goals and Activities

No separate strategic plan focuses solely on minority health, health disparities, or health equity. However, the HDH has an overarching strategic plan—last updated in August 2016—that describes Hawaii's strategic health priorities. Achieving health equity is a goal of the HDH, and as such, is integrated throughout much of the plan. The HDH updates the plan as new issues or objectives arise. To track and monitor Hawaii's progress toward the goals set forth in the strategic plan, HDH staff and others can access a dashboard reporting tool on the HDH website. The tool includes 21 metrics for monitoring the state's progress toward reaching the goals.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Hawaii Department of Health | HDH |
| Chronic Disease Prevention & Health Promotion Division | CDPHPD |
| Office of Health Equity | OHE |

Collection of statewide health-related surveillance and disparity data, in addition to monitoring of vital records, helps inform priority setting in Hawaii. Federal guidance and funding opportunities also aid the HDH in identifying priorities. Several other entities assist the HDH in some respect with setting goals, including the Native Hawaiian health community, the University of Hawaii, federally qualified health centers (FQHCs), the Hawaii Primary Care Association, and the Hawaii Public Health Institute.

The CDPHPD is working on many strategies to achieve health equity and eliminate health disparities. One focus of the CDPHPD is to improve quality of care and access to care by working with FQHCs and other partners. For example, staff are working to improve the diagnosis and management of asthma and diabetes, and to implement quality improvement processes at FQHCs for these two conditions. The CDPHPD is also working to implement self-management education and prevention programming at FQHCs. In addition, the CDPHPD is leading efforts to improve primary care access for patients with diabetes, hypertension, and/or asthma. Preventive strategies include increasing cancer screening rates by improving access to breast, cervical, and colorectal cancer screening throughout the state.

Language access services and cultural competency trainings are key strategies led by the CDPHPD with support from the Office of Language Access and the Bilingual Health Services unit. The CDPHPD is working to increase access to medical translation services for Micronesians and other limited and non-English-proficient cancer patients. The Bilingual Health Education Aide program provides interpretation and culturally sensitive health care access support and services for minority populations, including immigrants, migrants, Native Hawaiians, and people with limited or no English proficiency. The federally funded Easy Access Project provides an opportunity for newly arrived immigrants and migrants to receive a needs assessment and connect with a Bilingual Health Education Aide for support in navigating the health care system and obtaining health-related services.[4]

Several CDPHPD activities are underway to promote physical activity and healthy lifestyles. The CDPHPD is working with communities to promote physical activity through signage, worksite policies, social support, and joint use agreements. The CDPHPD is also involved in developing and implementing transportation and

4 State of Hawaii, Department of Health, Bilingual Health Services – Chronic Disease Prevention & Health Promotion. Available at the Hawaii Department of Health website. Last accessed 02/01/2017.

community plans that promote walking. The CDPHPD's Supplemental Nutrition Assistance Program Education (SNAP-Ed) promotes healthy eating among low-income populations through activities such as nutrition education, community gardens, and mobile produce markets. Staff are also working to increase access to healthy foods among SNAP participants by working with farmers markets to accept SNAP benefits through the electronic benefit transfer (EBT) system.

The CDPHPD's Tobacco Prevention and Education Program aims to promote tobacco cessation, prevent tobacco use among vulnerable and disparate populations, and protect non-smokers from tobacco smoke exposure.[5] Staff are conducting outreach to dentists, obstetricians and gynecologists, and Medicaid-accepting health care providers to promote Hawaii's Tobacco Quitline. The CDPHPD also leads efforts to train staff who work at organizations serving mostly at-risk, minority populations on conducting brief tobacco cessation interventions. Implementing smoke-free policies in public housing and improving access to cessation services are also key activities.

### Partnerships

| | |
|---|---|
| Primary collaborators | • University of Hawaii School of Medicine<br>• Hawaii Primary Care Association<br>• Federally qualified health centers<br>• Hawaii Public Health Institute<br>• Hawaii Department of Human Services |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

In addition to the work described above, the CDPHPD partners with many organizations to work toward achieving health equity in Hawaii. The University of Hawaii School of Medicine's Department of Native Hawaiian Health is a key partner on advocacy and policy initiatives pertaining to Native Hawaiians. The CDPHPD collaborates as a joint sponsor with the University of Hawaii School of Medicine on the state's combined medical-public health journal, *Hawai'i Journal of Medicine & Public Health*.

The HDH Mental Health Division contracts with an FQHC in Hawaii to provide mental health services to minority populations, and supports chronic disease prevention activities through this partnership. The CDPHPD also contracts with the Hawaii Public Health Institute, also known as the Coalition for a Tobacco-Free Hawaii. The Hawaii Public Health Institute collaborates with CDPHPD to implement strategies and programs to eliminate health disparities and improve the health of the state's population. Recent efforts through this partnership include the implementation of a bicycle sharing program in Honolulu and various tobacco cessation activities.

The CDPHPD also works closely with the Hawaii Department of Human Services, Hawaii State Medicaid agency on maternal and child health initiatives. Hawaii has adopted the "two-generation approach" that was developed by the Ascend Group at the Aspen Institute.[6] The CDPHPD collaboration with the Medicaid agency aims to carry out the two-generation approach by simultaneously delivering public health and social services to the parent in need and his or her children.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $12,944,000 (for the Hawaii Department of Health) |
| Annual budget (FY 2015) of SMHE from state/territorial government | $7,357,000 (for the Hawaii Department of Health) |
| Largest funding source | State of Hawaii |
| Anticipated changes to budget | No information obtained |

In FY 2015, the HDH had an annual budget of $12,944,000 for population health management activities. This includes six federal grants from the Centers for Disease Control and Prevention (CDC) to address a range of chronic diseases. CDC's Preventive Health and Health Services Block Grant helps support Hawaii's Easy Access Project that provides health-related services and support for immigrants and migrants.[7] The largest source of funding was from

5 State of Hawaii, Department of Health, Tobacco Control – Chronic Disease prevention & Health Promotion Division. Tobacco Prevention & Education Program. Available at the Hawaii Department of Health website. Last accessed 01/20/2017.

6 The Aspen Institute, Ascend. The Two-Generation Approach. Available at the Aspen Institute website. Last accessed 01/31/2017.

7 Centers for Disease Control and Prevention, Preventive Health and Health Services Block Grant. Hawaii. Available at the CDC website. Last accessed 02/01/2017.

the State of Hawaii, which includes funding for HDH staff salaries and the Bilingual Health Services unit. This state funding was supported by the Tobacco Settlement Special Fund allotment to the HDH.

The CDPHPD provides funding to several governmental and nongovernmental organizations for health promotion activities that aim to achieve health equity. In FY 2015, The Kohala Center, the YMCA, and Kokua Kalihi Valley received funding to provide nutrition education services for SNAP-eligible Hawaiians. Money is also allocated to FQHCs to address health disparities. In addition, the CDPHPD provides funding to the Hawaii Primary Care Association, the Hawaii Public Health Institute, the Hawaii Department of Education, the University of Hawaii Conference and Events Services, and the Honolulu Theatre for Youth to improve the health of Hawaiians.

# Hawaii

## Hawaii State Data

| Total Population[a]: 1,428,557 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 10.4 | 89.6 | 25.1 | 1.7 | 0.2 | 47.9 | 25.1 | 100.0 | NA |
| Percent of population medically uninsured[a] | 5.1 | 3.4 | 3.8 | 7.6 | 0.0 | 3.4 | 3.4 | 3.6 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 5.6 | 3.3 | SP | SP | 6.5 | NC | 5.7 | 5.9 |
| Age-adjusted mortality rate[b] | 897.4 | 554.5 | 634.2 | 487.1 | SP | 553.3 | NC | 572.0 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 25.8 | 16.4 | 13.3 | 17.3 | SP | 14.3 | 26.3 | 17.2 | 13.6 |
| Percent with diabetes[c] | 7.6 | 10.6 | 6.0 | 11.5 | SP | 13.3 | 11.0 | 10.5 | 10.8 |
| Percent with heart disease[c] | 1.8 | 3.7 | 4.1 | 6.6 | SP | 3.7 | 2.8 | 3.6 | 4.3 |
| HIV rate[d] | 315.4 | NC | 480.3 | 719.4 | 330.0 | 87.9** | 128.6 | 233.1 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 66.5 | 73.4 | 70.2 | 88.6 | SP | 77.2 | 67.2 | 72.8 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 67.7 | 73.7 | 74.4 | 86.7 | SP | 75.5 | 66.1 | 73.0 | 66.5 |
| Percent received flu vaccine[c] | 32.9 | 40.1 | 37.0 | 50.1 | SP | 43.6 | 34.6 | 39.4 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

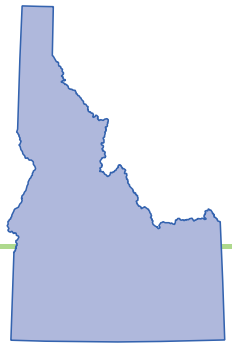
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 87.9 per 100,000 population (413 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 228.6 per 100,000 population (250 cases).

# Idaho



## Introduction to Idaho's Health Equity Activities

Idaho had an estimated 2016 population of 1,683,000. Hispanics/Latinos are the largest racial-ethnic minority population (12 percent), followed by Asian Americans and NHOPI (2 percent), American Indians/Alaska Natives (2 percent), and Blacks/African Americans (1 percent). Persons self-identifying as multiracial or "other race" comprise 7 percent of the population.[1] Approximately 532,000 Idaho residents live within a primary care health professional shortage area.[2]

Health equity activities are addressed by the Division of Public Health (DPH) of the Idaho Department of Health and Welfare (DHW). However, certain content areas within the DPH (e.g., tobacco prevention programs) have an explicit health equity component staffed by the DPH. Because many of the tobacco prevention activities are coordinated with the American Indian tribes, the DPH team has significant tribal experience and works closely with the DHW's tribal liaison. The DPH is moving the tobacco prevention specialist's organizational oversight to the DPH Deputy Director level or the DHW level, rather than serving through a specific grant. There is no standing committee or panel that advises the DPH on issues directly addressing minority health, health disparities, and health equity, but a representative group within the DPH reviews a health equity plan, which is one of the key initiatives of the Bureau of Community and Environmental Health.

### Idaho Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | N/A |
| Strategic plan in place to address minority health or health equity | None |
| Date strategic plan was last updated | N/A |
| Assessment plan in place to measure progress toward reducing health disparities | No |
| Key strategies used to achieve health equity | • Family planning program<br>• Pregnancy prevention programs<br>• Home visiting program<br>• HIV, STD, and hepatitis programs<br>• Project Filter<br>• Refugee health screenings |

## Organizational Structure

Idaho does not have a specific office dedicated to minority health, health disparities, and health equity, but these roles fall under the jurisdiction of the DPH. The DPH is part of the DHW, which reports directly to the governor. One DPH staff position is dedicated to health disparities activities; this health program specialist is funded by the Project Filter grant, but works with efforts across the DPH. For some DPH projects, volunteers are involved in health equity activities, but no regular volunteers or interns are primarily involved in these activities. Staffing allocations for health equity activities are not expected change.

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | Minority health is addressed by the DPH, which is located with the DHW. |
| SMHE staffing (full-time equivalents) | 1 |
| Advisory committee or panel | None |

## Program Goals and Activities

The State Health Improvement Plan uses data from the Behavioral Risk Factor Surveillance System, the U.S. Census, and other sources to identify populations facing health disparities. At-risk groups include rural and frontier area residents, low socioeconomic areas, Hispanic/Latino communities, and other minority populations. Several DPH programs seek to improve minority health, promote health equity, and reduce health disparities by targeting populations at highest risk for health disparities.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Division of Public Health | DPH |
| Department of Health and Welfare | DHW |

Health equity priorities within the DPH are often defined by requirements of the grants that fund its specific projects. For example, the DPH operates three programs funded by separate grants that all address family planning and maternal health. One, a family planning program aimed at adults at or below 150 percent of the federal poverty level, provides family planning services in all 44 Idaho counties and primarily serves rural and Hispanic residents. A pregnancy prevention program provides culturally specific programming and specifically targets Hispanic teens. Finally, a home visiting program partners with Idaho's seven local health districts to work with predominantly Hispanic pregnant women and new parents, most of whom are in rural and/or low socioeconomic areas.

Other programs that serve minority populations address STD prevention, smoking cessation, and health screenings for refugees. The DPH bureaus work together on an HIV, STD, and hepatitis program that has grant-specific requirements to address disparities in developing education, testing, and outreach strategies. In addition, the DPH collaborates with the Hispanic Cultural Center to provide HIV, STD, and hepatitis outreach to Hispanic communities. The Project Filter smoking cessation program, which seeks to decrease the population of smokers by three percent, targets American Indians and Alaska Natives and engages stakeholders from these communities. A refugee health program works exclusively with minority populations and provides physical and mental health screening services.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Local health districts<br>• Tribes and the Northwest Portland Area Indian Health Board<br>• Hispanic Cultural Center<br>• Allies Linked for the Prevention of HIV and AIDS ("a.l.p.h.a.")<br>• Idaho Primary Care Association<br>• State Department of Education<br>• Refugee resettlement agencies |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships (e.g., those with local health districts, a.l.p.h.a., the Hispanic Cultural Center, and others). |

To address minority health, health equity, and health disparities, the DPH collaborates with a range of organizations. It holds many contracts with local health districts that primarily serve American Indians, Hispanics/Latinos, and seasonal workers. The DPH also partners directly with American Indian tribes to address tobacco prevention objectives. It also collaborates with the Northwest Portland Area Indian Health Board, located in Portland, Oregon, which manages Idaho's tribal health data. Additionally, the DPH has contracts in place with the Hispanic Cultural Center and Allies Linked for the Prevention of HIV and AIDS ("a.l.p.h.a."). The DPH helps a.l.p.h.a. obtain HIV oral swab tests for use in alternative or non-medical settings. Other DPH partners include Idaho's Primary Care Association (which is comprised of community health centers and federally qualified health centers), the Idaho State Department of Education, and refugee resettlement agencies.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | There is no funding specifically for minority health entity. |
| Annual budget (FY 2015) of SMHE from state/territorial government | None |
| Largest funding source | N/A |
| Anticipated changes to budget | None |

No part of the DPH budget specifically funds activities related to minority health, health equity, or health disparities. However, the grant that funds Project Filter's anti-tobacco activities funds the health program specialist responsible for ensuring health equity for the grant. The DPH does not expect any changes to sources of funding or allocations over the next 2 years.

# Idaho

## Idaho State Data

| Total Population[a]: 1,683,140 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 12.3 | 87.7 | 89.5 | 0.6 | 1.5 | 1.7 | 6.6 | 100.0 | NA |
| Percent of population medically uninsured[a] | 24.2 | 8.8 | 9.9 | 10.0 | 22.2 | 11.9 | 18.1 | 10.7 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 5.0 | 4.9 | SP | SP | SP | NC | 4.7 | 5.9 |
| Age-adjusted mortality rate[b] | 498.3 | 736.9 | 730.9 | 421.1 | 589.3 | 425.9 | NC | 725.0 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 10.6 | 12.9 | 12.7 | SP | 17.6 | 0.2 | 10.6 | 12.7 | 13.6 |
| Percent with diabetes[c] | 9.0 | 9.0 | 8.6 | SP | 13.8 | 5.3 | 17.2 | 8.8 | 10.8 |
| Percent with heart disease[c] | 1.5 | 4.0 | 3.9 | SP | 5.5 | 0.0 | 0.9 | 3.9 | 4.3 |
| HIV rate[d] | 113.4 | NC | 67.7 | 1036.6 | 73.5 | 37.9** | 126.9 | 79.2 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 49.5 | 60.5 | 60.2 | SP | 54.8 | 60.9 | 57.0 | 59.9 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 54.4 | 64.7 | 64.0 | SP | 57.3 | 80.5 | 57.4 | 64.0 | 66.5 |
| Percent received flu vaccine[c] | 23.5 | 35.2 | 34.6 | SP | 30.4 | 37.1 | 20.0 | 34.3 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 37.9 per 100,000 population (7 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 0.0 per 100,000 population (0 cases).

# Illinois

## Introduction to Illinois' Health Equity Activities

Illinois had an estimated 2016 population of 12,802,000. Hispanics/Latinos are the largest racial-ethnic minority population (17 percent), followed by Blacks/African Americans (14 percent), Asian Americans and NHOP (5 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 9 percent of the population.[1] Approximately 3,847,000 Illinois residents live within a primary care health professional shortage area.[2]

In 1991, the Illinois General Assembly passed legislation creating the Center for Minority Health Services (CMHS). Its mission is to "improve the health and [well-being] of Illinois' racial and ethnic minority populations through the development of health policies and culturally linguistically appropriate programs that will eliminate health disparities."

### Illinois Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Illinois Department of Public Health, Center for Minority Health Services |
| Strategic plan in place to address minority health or health equity | The Center for Minority Health Services has a standalone strategic plan that is not publicly available. It aligns with the *Illinois Department of Public Health Five Year Strategy 2014 – 2018*, which identifies reducing health disparities as an overarching priority. |
| Date strategic plan was last updated | 2014 |
| Assessment plan in place to measure progress toward reducing health disparities | The Center for Minority Health Services has a plan in place for measuring progress towards health disparity reduction, as does the Illinois Department of Public Health. |
| Key strategies used to achieve health equity | • Increasing access to health care for underserved and underinsured communities through Wellness on Wheels mobile units<br>• Conducting flu shot clinics for uninsured and underinsured individuals<br>• Offering hepatitis B outreach and education to individuals of Asian and African descent<br>• Providing minorities with outreach and online eligibility assessment for enrollment into the AIDS Drug Assistance Program<br>• Conducting health screenings, outreach, health promotion, and services for newly arriving refugees |

## Organizational Structure

The CMHS addresses health disparities and minority health issues in Illinois. Located within the IDPH, it falls under the Office of the Director and is comprised of five full-time staff members (i.e., the CMHS chief, three program administrators, and an administrative assistant) who dedicate 100 percent of their time to minority health initiatives. Three additional IDPH program administrators work closely with the CMHS on minority health activities. In addition, the CMHS has one contractual epidemiologist for the Refugee Health Program and engages both paid and unpaid interns.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/ territorial government | The Center for Minority Health Services is housed within the Illinois Department of Public Health |
| SMHE staffing (full-time equivalents) | 5 |
| Advisory committee or panel | None |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

## Program Goals and Activities

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Illinois Department of Public Health | IDPH |
| Center for Minority Health Services | CMHS |

The *Illinois Department of Public Health Five Year Strategy 2014-2018*, last updated in 2014, identifies health disparity reduction as a key priority area. The CMHS also has its own strategic plan, which aligns with the goals and objectives of the IDPH. Both the CMHS and the IDPH have assessment plans in place to measure progress on their efforts.

Priorities for minority health, health disparities, and health equity in Illinois are set in a variety of ways. State legislative initiatives determine state-level funding for health equity activities. Within the IDPH, the CMHS is largely responsible for setting its own priorities, although grant awards and nongovernmental stakeholders can also influence its agenda.

A major focus of the CMHS is increasing access to preventive health care in medically underserved minority communities. The CMHS leads the Wellness on Wheels pwrogram, which offers free preventive health screenings and referrals through mobile units based in designated regions across the state. Each unit travels to various events and locations, thereby serving a range of populations across each region. Four of the five units were purchased by the CMHS with a grant from the U.S. Office of Minority Health. In addition to maintaining all five mobile units, the CMHS provides grant funding to the organizations that use these units to deliver preventive health services. In addition, the CMHS coordinates mobile unit scheduling when communities request a mobile unit for an event.

The CMHS also focuses on outreach and education efforts to address health disparities in Illinois. One initiative, funded through a CMHS grant program, provides Hepatitis B outreach, awareness, and education to foreign-born Asian and African immigrant and refugee communities. The program's goals include increasing screenings and vaccination rates, decreasing transmission rates, and reducing risky behaviors. Five grantees receive funding to produce culturally and linguistically competent educational materials that address cultural and societal issues that may result in screening/vaccination rate disparities. These grantees also provide referrals and connect individuals to screening and vaccination services.

In another outreach effort, the CDPH manages a grant program that provides outreach and education services designed to increase minority participation in the AIDS Drug Assistance Program. This program, funded through Part B of the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87), specifically targets minority populations and uninsured/underinsured individuals who may not be aware that they are eligible for free AIDS prescription drugs and other services through the AIDS Drug Assistance Program.

Many of the CMHS's activities support the Refugee Health Program, which is located within the CMHS and promotes the health of newly arriving refugees. The CMHS issues grant awards for the provision of health screenings to refugees arriving in Illinois. Screenings must be completed within 90 days of arrival in a culturally competent and linguistically appropriate setting. The CMHS issues additional grants to refugee-serving organizations to provide outreach, health promotion, interpretation, medical case management, nutrition, and mental wellness services. Grantees work with the CMHS to ensure that refugees receive health screenings and other necessary resources or services. The U.S. Department of Health and Human Services Office of Refugee Resettlement and the Illinois Department of Human Services provide funding for this grant program.

# Illinois

## Partnerships

| | | |
|---|---|---|
| Primary collaborators | • Asian Health Coalition<br>• Asian Human Services<br>• Aunt Martha's Aurora Community Health Center<br>• Brothers Health Collective<br>• Champaign Urbana Public Health District<br>• Community Health and Emergency Services<br>• DuPage County Health Department<br>• East Side Health District<br>• Fifth Street Renaissance<br>• Greater All Nations Tabernacle Church of God in Christ<br>• Heartland Health Outreach<br>• Illinois Department of Human Services | • Illinois Migrant Council<br>• Illinois Public Health Association<br>• Mexican Consulate in Chicago<br>• Midwest Asian Health Association<br>• Sinai Medical Group Touhy<br>• Pan-African Association<br>• Puerto Rican Cultural Center<br>• Regional CARE Association<br>• Rock Island County Health Department<br>• Springfield Urban League<br>• Walgreens<br>• Winnebago County Health Department<br>• World Relief DuPage/Aurora |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships (e.g., all CMHS grantees). | |

A strategic priority of the IDPH is to develop and expand partnerships to help improve the health of the people of Illinois. As such, working collaboratively with grantees to address minority health and health disparities is an overarching strategy used by the CMHS. By working with grantees, the CMHS leverages the unique expertise that local and regional organizations offer. For example, the Wellness on Wheels program discussed above relies on five organizations to operate the mobile units and provide preventive health screenings: Regional CARE Association, Champaign Urbana Public Health District, Community Health and Emergency Services, Springfield Urban League, and Fifth Street Renaissance. These organizations are geographically dispersed throughout Illinois, which allows the Wellness on Wheels program to provide free health services to medically underserved minority communities throughout the state.

As another example, the Refugee Health Program collaborates with a variety of organizations to provide health services to newly arriving refugees. For the provision of health screenings, the CMHS issues grant awards to five health care providers: Aunt Martha's Aurora Community Health Center, DuPage County Health Department, Rock Island County Health Department, Sinai Medical Group Touhy, and Winnebago County Health Department. The CMHS has formal relationships with other refugee-serving organizations through a grant program intended to complement the health screening program. Heartland Health Outreach, Pan-African Association, and World Relief DuPage/Aurora provide health outreach, health promotion, interpretation services, medical case management, nutrition services, and mental wellness services to refugee populations in Illinois. In addition, the CMHS collaborates with staff from the Illinois Department of Human Services to support the Refugee Health Program.

In another effort aimed at increasing access to preventive health care services, the CMHS helps organize flu shot clinics throughout the state. The CMHS links minority and underserved communities to a flu shot voucher program funded by Walgreens and the U.S. Department of Health and Human Services. Walgreens distributes vouchers through outreach efforts and at community events and, for those without health insurance, Walgreens provided a free flu shot through the voucher process. To further improve immunization rates in underserved communities, Walgreens provided screenings and vaccinations to individuals with insurance and helped them process claims.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $4,299,545 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $1,877,560 |
| Largest funding source | Federal government |

In FY 2015, the total funding for minority health activities in Illinois was $4,299,545. The CMHS received $1,877,560 from the State of Illinois and $2,421,985 in federal grant funding to support the strategies described in this summary. A significant portion of CMHS funding is allocated for grant awards; it typically issues 40 to 50 grant awards each year. While federal funding has been fairly consistent, state funding has decreased in recent years.

# Illinois

## Illinois State Data

| Total Population[a]: 12,801,539 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 17.0 | 83.0 | 71.2 | 14.2 | 0.2 | 5.4 | 9.0 | 100.0 | NA |
| Percent of population medically uninsured[a] | 15.7 | 4.8 | 5.3 | 7.4 | 14.0 | 6.6 | 15.8 | 6.6 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 5.3 | 6.2 | 4.7 | 12.4 | SP | 3.9 | NC | 6.0 | 5.9 |
| Age-adjusted mortality rate[b] | 450.7 | 746.1 | 707.0 | 948.5 | 141.7 | 363.7 | NC | 724.3 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 11.1 | 14.7 | 13.6 | 17.5 | 16.5 | 8.8 | 23.7 | 14.3 | 13.6 |
| Percent with diabetes[c] | 11.3 | 10.2 | 9.7 | 15.7 | 5.0 | 7.7 | 8.5 | 10.3 | 10.8 |
| Percent with heart disease[c] | 2.3 | 4.1 | 4.3 | 3.1 | 4.4 | 1.6 | 1.6 | 3.9 | 4.3 |
| HIV rate[d] | 405.7 | NC | 144.6 | 1101.9 | 199.8 | 76.1** | 1527.8 | 330.1 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 64.6 | 71.5 | 69.1 | 81.0 | 54.0 | 67.2 | 74.2 | 70.7 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 58.3 | 67.2 | 69.0 | 56.9 | 47.0 | 62.3 | 55.3 | 66.1 | 66.5 |
| Percent received flu vaccine[c] | 35.0 | 36.8 | 37.9 | 30.0 | 22.8 | 40.6 | 26.9 | 36.3 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

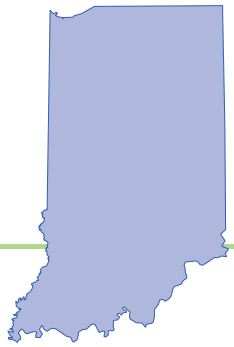
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 76.1 per 100,000 population (436 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 727.7 per 100,000 population (21 cases).

# Indiana



## Introduction to Indiana's Health Equity Activities

Indiana had an estimated 2016 population of 6,663,000. Blacks/African Americans are the largest racial-ethnic minority population (9 percent), followed by Hispanics/Latinos (7 percent), Asian Americans and NHOPI (2 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 5 percent of the population.[1] Approximately 3,260,000 Indiana residents live within a primary care health professional shortage area.[2]

The Indiana State Department of Health (ISDH) Office of Minority Health (OMH) was created in 1991. Its mission is "to improve the health of all racial and ethnic populations in Indiana through increased awareness, partnerships, and the development and promotion of effective health policies and programs that help to reduce minority health disparities."[3] The OMH is responsible for advancing the legislatively-mandated Minority Health Initiatives (Indiana Code 16-46-11).

### Indiana Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Minority Health |
| Strategic plan in place to address minority health or health equity | The Office of Minority Health is updating an existing strategic plan. |
| Date strategic plan was last updated | The Office of Minority Health last updated the strategic plan in 2010. |
| Assessment plan in place to measure progress toward reducing health disparities | The Office of Minority Health intends to include a plan for monitoring progress in the updated strategic plan. |
| Key strategies used to achieve health equity | • Advocating for the elimination of health disparities and increasing health equity<br>• Promoting culturally competent and linguistically appropriate services and health care delivery<br>• Promoting and supporting minority health efforts by obtaining funding for specific programs and initiatives<br>• Improving data collection, analysis, and dissemination of information |

## Organizational Structure

Housed within the ISDH, the OMH employs four full-time staff members—including the director, a health disparities epidemiologist, an office manager, and a project coordinator. The project coordinator is a grant-funded contracted position. In addition, the OMH engages unpaid interns throughout the year and, with funding from the Indiana Minority Health Coalition, paid interns in the summer. The OMH does not currently have a committee or panel that advises on minority health or health equity.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/ territorial government | The Office of Minority Health is housed within the Indiana State Department of Health. |
| SMHE staffing (full-time equivalents) | 4 |
| Advisory committee or panel | None |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 See the Indiana State Department of Health's webpage. Last accessed: October 2, 2017

## Program Goals and Activities

The OMH is revising an existing strategic plan, which was first launched in 2003 and updated most recently in 2010. In the upcoming version, which will be publicly available on its website, the OMH intends to include a plan for monitoring progress. A core function of the OMH is serving as a member of the Interagency State Council on Black and Minority Health, an organization that plays a key role in determining health equity priorities in Indiana. The OMH also relies on its partner organizations to help identify priorities.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Indiana State Department of Health | ISDH |
| Office of Minority Health | OMH |

An overarching focus of the OMH is to advocate for strategies that eliminate health disparities and increase health equity in Indiana. Raising awareness of health equity issues and creating linkages between partner organizations and state agencies is a related and key part of its scope, as is improving access to health care and health outcomes. In support of these goals, the OMH participates in a wide range of activities. For example, it sponsors the INShape Indiana Black and Minority Health Fair, which provides free health screenings at the annual Indiana Black Expo Summer Celebration. The OMH also works to incorporate health equity into ISDH policies (e.g., supporting efforts to increase workforce diversity, cultivate community-driven partnerships, and ensure outreach to key minority health stakeholders for their input into the ISDH's strategic planning process).

Another OMH objective is to promote culturally competent and linguistically appropriate services. To this end, the OMH trains staff from the ISDH and other state agencies about the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). Such educational activities promotes proficiency with the National CLAS Standards, which helps ensure that state services and resources are culturally appropriate. Additionally, the OMH seeks to promote cultural competency among partner organizations by, for example, helping to publicize the National CLAS Standards at an annual minority health conference and supporting cultural competency training for data collectors.

The OMH also helps to secure resources for specific programs and initiatives. For example, the OMH received funding from the U.S. Office of Minority Health State Partnership Grant Program, which supports the EMPOWERED ("Enhancing Minority Partnership Opportunities; Working to Eliminate Disparities") program. Through the EMPOWERED effort, the OMH collaborates with a range of statewide partners on health education initiatives on obesity, infant mortality, breastfeeding in minority populations, and smoking cessation. The OMH also collaborates with many partners to procure additional funding for health equity activities.

Improving the collection, analysis, and dissemination of racial and ethnic minority population data is another OMH priority. Together, the OMH and the ISDH Data Analysis Team have been advocating to increase the sample size of racial and ethnic minorities within Behavioral Risk Factor Surveillance System (BRFSS) surveys. Such oversampling would improve the reliability of sub-population estimates and aid efforts to identify and monitor disparities. The OMH also works with the Indiana Minority Health Coalition's Racial and Ethnic Minority Epidemiology Center to advance the State Master Research Plan, an effort to develop research strategies that reduce health disparities among racial and ethnic minorities. To support data analyses and dissemination, the OMH provides epidemiological support to internal and external partners. The OMH also works with the Interagency State Council on Black and Minority Health to release annual reports on the status of minority health in Indiana.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Indiana Black Expo<br>• Indiana Latina Expo<br>• Indiana Minority Health Coalition<br>• Interagency State Council on Black and Minority Health<br>• Local community advocacy groups |
| Contracts or memoranda of understanding with any partners | Formal contracts or memoranda of understanding are implemented for some partnerships. |

Many of the minority health efforts undertaken by the OMH rely heavily on external help. The OMH, therefore, partners with many governmental and nongovernmental organizations. For example, to convene the INShape Indiana Black and Minority Health Fair, the OMH established a formal contract with Indiana Black Expo, a nonprofit community service organization.

# Indiana

Another key OMH partner is the Indiana Minority Health Coalition, a statewide nonprofit agency with whom the OMH formally contracts to support implementing legislatively mandated Minority Health Initiatives. The Indiana Minority Health Coalition receives state funding through these initiatives, which it then distributes to local minority health coalition affiliates and community-based organizations.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $460,867 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $261,000 |
| Largest funding source | State government |

The total FY 2015 funding for the OMH was $460,867. In FY 2015, the office had two primary funding sources: the State of Indiana ($261,000) and a 5-year State Partnership Initiative to Address Health Disparities grant from the U.S. Office of Minority Health ($199,867). The OMH provides about $45,000 of its budget to support the annual INShape Indiana Black and Minority Health Fair.

The State of Indiana appropriates additional funding for the Minority Health Initiatives. In FY 2016, the Indiana General Assembly appropriated more than $2 million to the legislatively mandated Minority Health Initiatives. The OMH is responsible for directing the Minority Health Initiatives and dispersing those funds to partner organizations.

# Indiana

## Indiana State Data

| Total Population[a]: 6,633,053 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 6.8 | 93.2 | 83.5 | 9.3 | 0.3 | 2.2 | 4.7 | 100.0 | NA |
| Percent of population medically uninsured[a] | 20.1 | 7.5 | 7.8 | 9.7 | 13.4 | 6.7 | 14.5 | 8.3 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 8.1 | 7.3 | 6.7 | 11.9 | SP | SP | NC | 7.3 | 5.9 |
| Age-adjusted mortality rate[b] | 441.6 | 846.5 | 828.4 | 980.2 | 203.4 | 414.7 | NC | 835.0 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 11.1 | 14.6 | 13.7 | 20.6 | 31.4 | 8.9 | 27.3 | 14.5 | 13.6 |
| Percent with diabetes[c] | 8.8 | 11.7 | 11.2 | 15.9 | 16.1 | 6.4 | 13.7 | 11.6 | 10.8 |
| Percent with heart disease[c] | 2.2 | 4.9 | 5.0 | 4.4 | 7.8 | 0.2 | 4.3 | 4.9 | 4.3 |
| HIV rate[d] | 306.6 | NC | 120.5 | 780.6 | 38.5 | 148.0** | 564.2 | 195.7 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 54.3 | 68.4 | 68.0 | 71.6 | 52.3 | 58.7 | 64.5 | 68.0 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 53.9 | 63.0 | 63.9 | 50.3 | 44.9 | 63.8 | 60.9 | 62.5 | 66.5 |
| Percent received flu vaccine[c] | 28.5 | 38.3 | 38.6 | 30.8 | 22.0 | 34.1 | 46.7 | 37.9 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

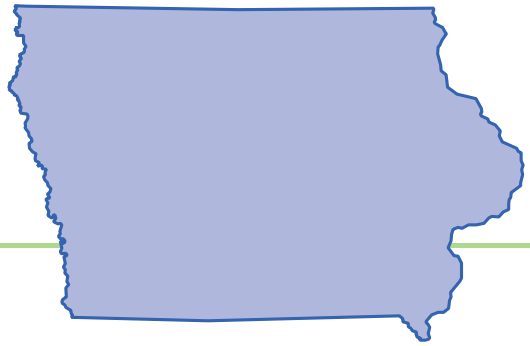
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 148.0 per 100,000 population (169 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 0.0 per 100,000 population (0 cases).

# Iowa



**Special Note:** The Office of Minority and Multicultural Health (OMMH) was not reauthorized by the Iowa state legislature effective July 1, 2017. The mission and functions of the OMMH are being integrated throughout the Iowa Department of Public Health.

## Introduction to Iowa's Health Equity Activities

Iowa had an estimated 2016 population of 3,135,000. Hispanics/Latinos are the largest racial-ethnic minority population (6 percent), followed by Blacks/African Americans (4 percent), Asian Americans and NHOPI (3 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 3 percent of the population.[1] Approximately 727,000 Iowa residents live within a primary care health professional shortage area.[2]

The Iowa Department of Public Health (IDPH) formed an Office of Minority Health in 2005; state law mandated its establishment in 2006.[3] In 2010, its name changed to the Office of Minority and Multicultural Health. The OMMH is housed in the Bureau of Oral Health and Delivery Systems within the IDPH Division of Health Promotion and Chronic Disease Prevention. The OMMH's mission is to "promote and facilitate health equity" with the vision of "100 percent health care access and zero percent health disparity for Iowa's minority and multicultural communities."[4] A key emphasis of the OMMH is promoting cultural competency within the health care community. The 15-member OMMH Advisory Council is appointed by the health department director to inform and support OMMH activities to achieve health equity in Iowa.

### Iowa Minority Health Overview

| | |
|---|---|
| Name of state/territorial minority health entity | Office of Minority and Multicultural Health |
| Strategic plan in place to address minority health or health equity | The Iowa Department of Public Health Office of Minority and Multicultural Health's Strategic Plan. |
| Date strategic plan was last updated | 2015 |
| Assessment plan in place to measure progress toward reducing health disparities | The assessment plan is a part of the larger Healthy Iowans strategic plan that evolved from a statewide needs assessment. *Healthy Iowans: Iowa's Health Improvement Plan* focuses on measurable goals and tracks progress on statewide health issues.[5] |
| Key strategies used to achieve health equity | • Trainings for all new department staff about social determinants of health<br>• Department-wide training on the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care<br>• Breast and cervical cancer screening outreach to Latino women<br>• Quarterly Advisory Council meetings<br>• Coordination with "Des Moines Age-Friendly City Initiative" |

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.
3 Iowa Department of Public Health. Minority and Multicultural Health: What We Do Profile.
4 Iowa Department of Public Health. Office of Minority and Multicultural Health Strategic Plan, 2012 to 2017.
5 Iowa Department of Public Health. "Iowa's Health Improvement Plan 2012-2016: 2015 Revisions." Website of the IDPH. Last accessed December 1, 2017

## Organizational Structure

State legislators created the OMMH in 2006 to address health disparities and minority health issues in Iowa. Administrative rules were promulgated in 2011 to establish the OMMH Advisory Council, which consists of 15 voting members from designated regions and public- and private-sector organizations.

The OMMH has one full-time staff member, the executive officer, who dedicates half of her time to minority health and health equity initiatives. Beyond this executive officer position, the OMMH regularly engages unpaid interns (and, when grant funding is available, paid interns) to help with its activities. No upcoming staffing changes were anticipated at the time of data collection.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The OMMH is housed in the Bureau of Oral Health and Delivery Systems within the Iowa Department of Public Health, Division of Health Promotion and Chronic Disease Prevention. |
| SMHE staffing (full-time equivalents) | 0.5 |
| Advisory committee or panel | OMMH Advisory Council |

## Program Goals and Activities

OMMH 2012 Strategic Plan, *Healthy Iowans: Iowa's Health Improvement Plan 2012-2016*, is publicly available on the OMMH's website. It implements methods to increase health care access and reduce disparities in health outcomes among racial and ethnic minorities, immigrants, and refugee populations in Iowa. Developed with input from the OMMH Advisory Council and other stakeholder organization leaders, the strategic plan outlines the core functions and strategic initiatives of the OMMH. The plan spans FY 2012 to 2017, and the previous one covered FY 2007 to 2011.

The OMMH sets priorities both through the strategic plan and the OMMH Advisory Council. State policymakers, along with public and private sector partners and stakeholders, help identify areas of focus. Additionally, recent grant funding opportunities are including more language specifically addressing health equity and disparities, which is also driving minority health priorities throughout the state.

Iowa tracks health indicators both to identify trends and establish benchmarks, allowing for comparisons to other states. Specifically, Healthy Iowans is a publicly available statewide population health plan that measures progress toward reducing health disparities and achieving health equity in Iowa. Its development involved stakeholder organizations and individuals across the state.[6]

A major focus of the OMMH is increasing cultural competency in health care. The OMMH trains all new IDPH employees about social determinants of health using the interactive Life Course Game. Game participants take on a role with specific social and biological risk and protective factors that lead to varied health outcomes. The training concludes with a discussion on the social determinants of health in the populations served by the IDPH. In addition, the OMMH offers a department in-service training on the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) as part of its effort to increase communication across all department employees. The National CLAS Standards training is available on request by bureaus and programs associated with the IDPH.

Another OMMH activity to promote health equity involves targeted outreach to vulnerable populations. For example, the OMMH works with the IDPH Bureau of Chronic Disease Prevention and Management (BCDPM) to develop specific strategies that encourage breast and cervical cancer screenings among Latino women. The joint OMMH/BCDPM team has identified communities with large numbers of underserved Latino women, and discussions with community members have helped guide outreach.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Iowa Department of Public Health | IDPH |
| Office of Minority and Multicultural Health | OMMH |
| IDPH Bureau of Chronic Disease Prevention and Management | BCDPM |

6 Ibid.

The OMMH also promotes networking across programs and initiatives related to health equity. Through quarterly OMMH Advisory Council meetings, the OMMH gains input about IDPH initiatives. For example, the Advisory Council has provided input on the state's tobacco cessation programing efforts to reach under-reached or vulnerable populations. Additionally, the OMMH's executive director has attended several meetings on the Des Moines "Age-Friendly City Initiative" to better understand and represent the needs of minority and multicultural populations.

### Partnerships

| | |
|---|---|
| Primary collaborators | Selected list includes:<br>• Iowa Comprehensive Cancer Consortium<br>• Polk County Health Department<br>• Region VII Health Equity Heartland Advisory Council<br>• Title V Maternal and Child Health Services Block Grant Program<br>• Several Iowa academic institutions |
| Contracts or memoranda of understanding with any partners | No partnerships include formal contracts or memoranda of understanding. |

Governmental and nongovernmental organizations partner with the OMMH to work toward eliminating health disparities and advancing statewide health equity. For example, the OMMH coordinates with the Polk County Health Department on the Des Moines Age-Friendly City Initiative. Additionally, the OMMH partners with the federal Title V Maternal and Child Health Services Block Grant Program in the Bureau of Family Health by providing trainings on request and at semiannual meetings with contractors. No formal contract exists between the OMMH and the Title V Program, but the OMMH executive officer's position description includes language calling for coordination with the Program. Together, the OMMH and Title V Program work toward reaching national goals and objectives related to minority and multicultural health and health disparities.

Although there is no formal contract between them, the OMMH executive officer regularly participates in meetings of the IDPH-funded Iowa Comprehensive Cancer Consortium to share data and represent the issues and needs of underserved populations. The OMMH executive officer also is a member of the Region VII Heartland Regional Health Equity Council and works with the Council to enhance data collection and reporting efforts across rural states.

Finally, the OMMH partners with several public and private academic institutions to improve health equity in Iowa, presenting on specific minority and multicultural health topics upon request. It also regularly coordinates with Des Moines University and other schools to recruit for preceptorships and internships. The OMMH has established formal agreements for student experiences as required by IDPH and each institution.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $120,315 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $37,768 |
| Largest funding source | Federal Title V Block Grant |
| Anticipated changes to budget | Possible changes to flexibility in use of funds |

The total FY 2015 funding for the OMMH was $120,315. In FY 2015, the office had two key funding sources: the federal Title V Block Grant ($82,547) and the state cervical cancer screening appropriation ($37,768). The Title V Block Grant for child health care was consistent at that level from FY 2013 to FY 2015, while the state cervical cancer screening funding was a one-time appropriation. The OMMH did not provide any funding to other governmental or nongovernmental entities for health disparities or health equity activities in FY 2015.

Funding for the OMMH became a separate line item in the IDPH budget in FY 2016 due to an IDPH reallocation request approved by the governor's office. This reallocated state funding is set aside specifically for the OMMH to support the office's 0.5 full-time equivalent position that was previously funded through shared support across IDPH programs. No upcoming funding changes for the OMMH were anticipated at the time of data collection, but IDPH has been involved in conversations with legislators with the goal of increasing the flexibility of funds appropriated to the IDPH.

# Iowa

## Iowa State Data

| Total Population[a]: 3,134,693 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 5.7 | 94.3 | 90.3 | 3.5 | 0.4 | 2.6 | 3.3 | 100.0 | NA |
| Percent of population medically uninsured[a] | 14.4 | 3.5 | 3.8 | 6.3 | 9.5 | 3.7 | 12.2 | 4.2 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 4.4 | 4.0 | 8.1 | SP | SP | NC | 4.2 | 5.9 |
| Age-adjusted mortality rate[b] | 400.6 | 726.9 | 718.3 | 962.6 | 569.8 | 403.1 | NC | 721.1 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 11.4 | 12.1 | 12.0 | 10.3 | SP | 6.9 | 16.6 | 12.2 | 13.6 |
| Percent with diabetes[c] | 9.2 | 9.4 | 9.4 | 6.6 | SP | 4.7 | 10.8 | 9.3 | 10.8 |
| Percent with heart disease[c] | 1.0 | 4.1 | 4.1 | 0.0 | SP | 0.0 | 2.2 | 3.9 | 4.3 |
| HIV rate[d] | 180.6 | NC | 68.2 | 574.0 | 54.9 | 96.0** | 423.9 | 93.5 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 67.2 | 72.5 | 72.7 | 76.5 | SP | 56.7 | 69.7 | 72.4 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 73.8 | 71.6 | 72.7 | 65.7 | SP | 61.4 | 60.4 | 71.8 | 66.5 |
| Percent received flu vaccine[c] | 37.0 | 47.1 | 47.8 | 33.3 | SP | 41.2 | 38.0 | 46.8 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

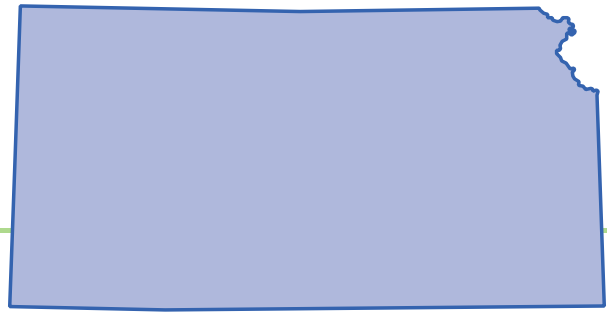
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 96.0 per 100,000 population (58 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 0.0 per 100,000 population (0 cases).

# Kansas



## Introduction to Kansas' Health Equity Activities

Kansas had an estimated 2016 population of 2,907,000. Hispanics/Latinos are the largest racial-ethnic minority population (12 percent), followed by Blacks/African Americans (6 percent), Asian Americans and NHOPI (3 percent), and American Indians/Alaska Natives (1 percent). Persons self-identifying as multiracial or "other race" comprise 6 percent of the population.[1] Approximately 802,000 Kansas residents live within a primary care health professional shortage area.[2]

Minority health and health equity activities in Kansas are coordinated through the Special Population Health (SPH) section of the Kansas Department of Health and Environment's (KDHE) Bureau of Community Health Systems (BCHS). Its predecessor, the Center for Health Equity, lost funding in 2012. Since then, issues addressing health disparities and minority health have been under the Bureau's SPH purview, although other Bureau initiatives have also addressed health equity issues. There is no advisory committee or panel for minority health, health disparities, or health equity issues in the KDHE.

### Kansas Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | No standalone entity. The Bureau's SPH coordinates minority health activities. |
| Strategic plan in place to address minority health or health equity | No strategic plan specific to minority health or health equity is available. |
| Date strategic plan was last updated | N/A |
| Assessment plan in place to measure progress toward reducing health disparities | None |
| Key strategies used to achieve health equity | • Increasing farmworker access to health care through the Kansas Statewide Farmworker Health Program<br>• Enhancing emergency preparedness in Native American tribes<br>• Development and distribution of a video, Health in 3D: Diversity, Disparities, and Social Determinants<br>• Development of a website to promote cultural competency in nursing care |

## Organizational Structure

Minority health and health equity activities are managed through the Kansas Department of Health and Environment's Bureau of Community Health Systems, Special Population Health section. Promoting minority health and health equity is a new role for the Bureau's SPH, which has one full-time staff member. This position dedicates the majority of time to the Kansas Statewide Farmworker Health Program and approximately 5 percent of time to health equity and minority health efforts. No staffing changes are anticipated.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/ territorial government | Minority health activities are coordinated through the KDHE Bureau of Community Health Systems' SPH. |
| SMHE staffing (full-time equivalents) | 0.05 |
| Advisory committee or panel | None |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

## Program Goals and Activities

No strategic plan specific to minority health and health equity is available. To develop its health equity-related priorities, the Bureau's SPH director is gathering information on programs within the KDHE to catalogue existing health equity efforts and identify gaps. In addition, the KDHE's department-wide strategic plan emphasizes consideration of health equity across programs and initiatives. The BCHS's SPH section promotes farmworker access to health care, emergency preparedness in Native American tribes, and development of educational resources on cultural competency in health care delivery.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Bureau of Community Health Systems | BCHS |
| Kansas Department of Health and Environment | KDHE |
| Special Population Health | SPH |

The Kansas Statewide Farmworker Health Program (KSFHP), established in 1994 and managed by the Bureau's SPH section, helps low-income migrant and seasonal farmworkers and their families access health care services. A grant from the U.S. Health Services and Resources Administration supports services that families receive as part of this program. The Bureau's SPH section also provides education to farmworkers on such health issues as tobacco use, diabetes, and hypertension. Outreach emphasizes the importance of exercise, annual physical exams, vaccinations, colorectal cancer screenings, and prenatal care. Because 75 percent of KSFHP clients are Latino and 24 percent are Low-German Mennonites, the SPH section distributes educational materials in English, Spanish, and German. Bilingual staff are available to communicate information directly with each of these populations.

Public health preparedness is a priority of the BCHS. Kansas' four federally recognized Native American tribes receive federal grant dollars through the Bureau's Public Health Emergency Preparedness Cooperative Agreement. These funds support the SPH section's efforts to ensure that the tribes have adequate resources, including physician coverage, should emergencies occur.

In addition to these activities, the BCHS—supported by staff from the SPH section and in partnership with the REACH Healthcare Foundation—developed a 25-minute self-study web-based training module and accompanying video to explain how diversity, disparities, and social determinants (the "three Ds") play a role in Kansas' public health. Entitled "Health in 3D: Diversity, Disparities, and Social Determinants," the video is being widely distributed to local health departments, federally-qualified community health centers, and other partners, who are all encouraged to share the DVDs broadly. The module and video is also available as a publicly accessible course on "Kansas TRAIN," an online educational resource. To emphasize the range of demographics present throughout the state, the video includes interviews of Kansans representing several groups, including rural residents; Spanish-speaking populations; and lesbian, gay, bisexual, and transgender communities. Bureau staff are also involved in developing the Kansas Action Coalition's website, Kansas Center for Cultural Competency Advancement, which will provide information to nurses on implementing culturally congruent nursing care.

### Partnerships

| | |
|---|---|
| Primary collaborators | • REACH Healthcare Foundation<br>• Kansas Action Coalition<br>• Health clinics, local health departments, and federally-qualified community health centers across Kansas |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

Several organizations partner with the Bureau's SPH section to eliminate health disparities and advance statewide health equity. For example, the REACH Healthcare Foundation provided funding for the educational video, Health in 3D: Diversity, Disparities, and Social Determinants. Multiple members of the BCHS's Local Public Health Program staff serve on the Kansas Action Coalition, a body focused on supporting Kansan nurses by implementing the Institute of Medicine's 2010 report, entitled Future of Nursing: Leading Change, Advancing Health. With BCHS support, the Coalition is developing a website for the Kansas Center for Cultural Competency Advancement—an organization dedicated to promoting a culturally competent statewide nursing workforce.

# Kansas

Through the Kansas Statewide Farmworker Health Program, the Bureau's SPH section has contracts with about 700 clinics throughout Kansas, including local health departments, federally-qualified community health centers, hospitals, private providers, dentists, and pharmacies. Each partner has a signed provider agreement formalizing the partnership. Staff with the Bureau's SPH section supports several clinics serving large communities of farmworkers to help make appointments, follow up on bills, and schedule meetings. Bureau staff may only coordinate with other clinics when particular farmworker families need services.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | N/A |
| Annual budget (FY 2015) of SMHE from state/territorial government | N/A |
| Largest funding source | N/A |
| Anticipated changes to budget | None |

There was no dedicated funding for minority health and health equity activities in the Bureau's SPH section; no funding changes are anticipated.

# Kansas

## Kansas State Data

| Total Population[a]: 2,907,289 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 11.6 | 88.4 | 84.6 | 6.0 | 0.7 | 2.8 | 5.9 | 100.0 | NA |
| Percent of population medically uninsured[a] | 20.0 | 7.1 | 7.4 | 16.8 | 11.0 | 8.4 | 17.6 | 8.6 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 5.9 | 5.9 | 5.6 | 9.4 | SP | SP | NC | 6.0 | 5.9 |
| Age-adjusted mortality rate[b] | 507.7 | 765.6 | 750.4 | 935.1 | 984.7 | 422.1 | NC | 756.8 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 9.8 | 13.4 | 12.9 | 17.7 | 23.4 | 2.4 | 18.6 | 13.3 | 13.6 |
| Percent with diabetes[c] | 6.3 | 9.7 | 9.1 | 14.6 | 10.2 | 5.1 | 9.9 | 9.4 | 10.8 |
| Percent with heart disease[c] | 0.9 | 4.2 | 4.0 | 3.0 | 5.0 | 0.6 | 4.4 | 3.9 | 4.3 |
| HIV rate[d] | 205.8 | NC | 76.6 | 519.5 | 40.9 | 50.2** | 346.3 | 118.6 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 55.8 | 69.9 | 69.0 | 71.5 | 70.3 | 67.4 | 56.0 | 68.9 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 58.3 | 68.1 | 68.9 | 59.1 | 49.1 | 71.0 | 53.7 | 67.6 | 66.5 |
| Percent received flu vaccine[c] | 29.6 | 38.6 | 39.2 | 29.4 | 24.5 | 31.9 | 31.1 | 38.0 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

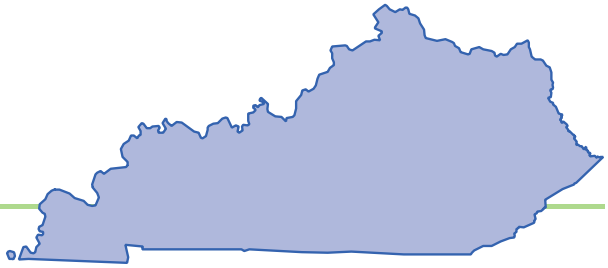
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 50.2 per 100,000 population (34 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 55.3 per 100,000 population (1 case).

# Kentucky



## Introduction to Kentucky's Health Equity Activities

Kentucky had an estimated 2016 population of 4,437,000. Blacks/African Americans are the largest racial-ethnic minority population (8 percent), followed by Hispanics/Latinos (3 percent), Asian Americans and NHOPI (2 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 3 percent of the population.[1] Approximately 1,117,000 Kentucky residents live within a primary care health professional shortage area.[2]

Kentucky's Office of Health Equity (OHE), established in 2008, is housed in the Commissioner's Office of the Kentucky Department of Public Health (KDPH). The KDPH is part of Kentucky's Cabinet for Health and Family Services, whose secretary reports directly to the governor. As part of the KDPH's executive leadership, the OHE is able to respond promptly to ideas, planning, and implementation of health equity initiatives. The OHE strives to "address health disparities among racial and ethnic minorities, and rural Appalachian populations."[3] An internal OHE advisory committee comprised of division directors and assistant directors provides strategic guidance.

### Kentucky Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Health Equity |
| Strategic plan in place to address minority health or health equity | No strategic plan. The OHE uses a yearly work plan of activities based on state needs. |
| Date strategic plan was last updated | N/A |
| Assessment plan in place to measure progress toward reducing health disparities | The OHE uses 5- and 10-year health status and health outcomes trend data to measure progress. |
| Key strategies used to achieve health equity | • Promoting community-based participatory research<br>• Disseminating data on health disparities<br>• Promoting use of evidence-based strategies related to chronic disease prevention and management<br>• Educating on social determinants of health and their impact on health outcomes<br>• Using a health equity framework to address health disparities |

## Organizational Structure

Located within the KDPH Commissioner's Office, the OHE "provides input using a health equity lens for numerous initiatives and committees" at the local, state, and national level.[4] Its internal Health Equity Advisory Committee strives to provide insight and guidance on OHE areas of focus.

The OHE has one full-time managing epidemiologist and one half-time program assistant who devotes 60 percent time to minority health and health equity initiatives. The epidemiologist provides oversight and guidance on health equity initiatives, funding opportunities, collaborations and partnerships, curriculum development and training, interpretation of data, and other duties. The program assistant oversees administrative activities and supports KDPH staff in cultural competency, cultural sensitivity, and health literacy. Beyond these two positions, staff across the KDPH work to support the OHE's health equity mission.

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.
3 Available on the Kentucky Cabinet for Health and Family Services, Office of Health Equity website. Last accessed July 10, 2017.
4 Ibid.

Other staffing support comes from community volunteers, who participate on several initiatives. The OHE serves as a University of Louisville School of Public Health and University of Kentucky School of Public Health practicum placement site where students can gain experience in health disparities and health equity work. No upcoming staffing changes are anticipated at this time.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The OHE is housed within the Kentucky Department of Public Health's Commissioner's Office |
| SMHE staffing (full-time equivalents) | 1.5 |
| Advisory committee or panel | Health Equity Advisory Committee |

## Program Goals and Activities

Based on the State Health Assessment and State Health Improvement Plan, the OHE develops and follows a work plan that includes specific initiatives. Internal discussions are underway for more formal strategic planning.

The OHE promotes the use of a health equity framework across all OHE and KDPH activities, with attention to root causes that impact population health. OHE priorities are data-driven and based on geographic and population-specific needs. The OHE uses Behavioral Risk Factor Surveillance System (BRFSS) data, the Office of Health Policy's hospitalization and emergency department data, and the OHE's own Kentucky Minority Health Status Report to identify issues that need to be addressed. Kentucky law requires the OHE to produce a Minority Health Status Report every 2 years that includes data stratified by race and ethnicity. The OHE also uses information from community-based organizations and coalitions to shape its work plan to address community needs.

To assess progress toward reducing health disparities, the OHE looks at trends in health status and health outcomes over 5- and 10-year periods. It is currently developing a rubric for measuring health equity. OHE areas of focus also align with federal priorities from the National Partnership for Action and state priorities from the state health assessment, the State Health Improvement Plan, Healthy People 2020, and the governor's Kentucky Health Now Plan.

In support of the National Partnership for Action focus areas, the OHE promotes community-based participatory research through several activities. For example, the OHE participated in Bless Your Heart, a Million Hearts initiative of the American Heart Association that used a faith-based model to encourage African American congregants with hypertension to reduce blood pressure. Similar faith-based models are also used in Eastern Kentucky for cancer prevention and HIV and human papillomavirus prevention. Through community health action teams funded by the Centers for Disease Control and Prevention, the OHE supports community-based participatory research through neighborhood associations. The OHE also works closely with the University of Louisville and the University of Kentucky to promote community-based participatory research and is planning to administer small community-based participatory research grants to local health departments on community safety, health, and wellness.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Kentucky Department for Public Health | KDPH |
| Kentucky Office of Health Equity | OHE |

The OHE works with divisions across the KDPH on translation and dissemination of state and local data on health disparities. By disseminating data in lay language, the OHE helps communicate to a broad audience what the numbers mean and how they impact populations, communities, and individual health. Using data from the aforementioned sources, coupled with the HIV/AIDS Surveillance Report and county health rankings, the OHE develops infographics that identify disparities and inequities for specific populations. It then disseminates these infographics to KDPH workgroups, coalitions, community-based partners, and to the public via the KDPH website. The OHE is developing infographics on chronic disease impact that convey morbidity and mortality in communities and populations across the state.

Chronic disease prevention is a priority area for the OHE. It provides technical assistance on the health equity components of such work across the department. The OHE also supports the Health Access Nurturing Development Services program for expectant parents and Kentucky's Women's Cancer Screening Program—which uses community health workers to reach women. Other programs supported by OHE include Health

Homes and Kentucky's CARE Collaborative for heart disease and stroke prevention. It uses geographic, demographic, and poverty-level data to target populations for evidence-based interventions to ensure access to quality health care and services.

Education is a key strategy employed by the OHE, which conducts trainings for KDPH employees, community-based partner organizations, and the general public. The OHE emphasizes awareness and education around social determinants and provides standardized definitions of health disparities, health equity, and social justice. It continually educates its internal and external partners on what those terms mean, how they impact health, and how they apply to their programs. For example, the OHE conducts in-person trainings, workshops, and small group seminars to educate the public health workforce to better address population health. Online trainings are also available as web-based courses on Kentucky's Training Finder Real-time Affiliate Integrated Network (TRAIN), an online learning resource of the Public Health Foundation. The OHE conducts a Bridges Out of Poverty training that emphasizes that poverty can be situational, generational, and a strong driver of stakeholder decisions. The Bridges Out of Poverty training includes a follow-up component called Bridges Into Health that focuses on health care and health services.

### Partnerships

| | |
|---|---|
| Primary collaborators | • City of Louisville's Center for Health Equity<br>• Health Equity Network<br>• KDPH Chronic Disease Prevention Branch<br>• Kentucky Cancer Consortium<br>• University of Louisville School of Public Health and Information Sciences |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships |

The OHE partners with state and local health departments, community and faith-based organizations, neighborhood associations, coalitions, academic institutions, internal KDPH programs, and other state and local government agencies.

The OHE has worked with the City of Louisville's Center for Health Equity since 2008. Like the OHE, the Center for Health Equity aims to expand the definition of health equity and health inequities and focuses on how policy and systems changes can promote health equity in specific populations. The OHE communicates regularly with the center in an effort to expand initiatives beyond Louisville and Jefferson County, where the center is well established. Together, the OHE and Center for Health Equity are working on general health equity policies, and seeking to help communities understand regulations and have a voice for health equity.

The Kentucky Cancer Consortium consists of about 60 profit and nonprofit organizations that meet quarterly to discuss five focus areas of cancer: cancer prevention, screening, quality of life, survivorship, and treatment. The consortium forms workgroups to address each area and determine needs for specific populations based on race/ethnicity, age, geography, and gender. The OHE and the consortium are working on health literacy and survivorship issues, with an emphasis on lung cancer screening and policy, since lung cancer is the leading cause of cancer morbidity and mortality in the state. The OHE has a memorandum of understanding regarding its partnership with the Consortium.

The OHE works with the KDPH Chronic Disease Prevention Branch on health disparities initiatives related to colorectal cancer, heart disease, stroke, asthma, and diabetes. For example, the OHE is working with the Chronic Disease Prevention Branch to increase colorectal cancer screening for African American men in urban areas.

Another partner is the Health Equity Network, originally created through an OHE grant, which continues its health equity work in Lexington County. The OHE provides technical assistance and guidance to the network on health disparities, social determinants of health, and health equity issues. It also helps the network find ways to leverage data to address critical access issues and areas of need within certain communities. The Health Equity Network is collaborating with medical associations to decrease community violence and bullying among children and is seeking ways to involve law enforcement, schools, and the wider community.

Finally, the University of Louisville School of Public Health and Information Sciences coordinates with the OHE to educate students, faculty, and staff on cultural competency and health literacy. Together, the OHE and the University are developing initiatives to support undergraduate students and prepare them for graduate studies or professional careers based on an understanding of the social determinants of health. The OHE has conducted lectures at the university, and has provided workshops and training materials.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $150,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | None |
| Largest funding source | State Partnership Initiative to Address Health Disparities grant from the U.S. Office of Minority Health |
| Anticipated changes to budget | Possible changes to flexibility in use of funds |

The total FY 2015 funding for the OHE was $150,000, all from the State Partnership Initiative to Address Health Disparities grant from the U.S. Office of Minority Health. Subsequently, OHE funding has remained consistent at approximately $150,000 since 2016, funded by the federal Preventive Health and Health Services Block Grant and state resources. The OHE provides limited funding to county and local health departments to address health disparities.

No funding changes for the OHE are anticipated.

# Kentucky

## Kentucky State Data

| Total Population[a]: 4,436,974 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 3.4 | 96.6 | 87.1 | 8.4 | 0.2 | 1.5 | 2.8 | 100.0 | NA |
| Percent of population medically uninsured[a] | 21.3 | 5.0 | 5.2 | 7.0 | 3.9 | 7.4 | 11.6 | 5.5 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 6.8 | 6.6 | 8.9 | SP | SP | NC | 6.7 | 5.9 |
| Age-adjusted mortality rate[b] | 349.8 | 946.6 | 941.8 | 967.9 | 215.9 | 406.1 | NC | 938.4 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 14.7 | 15.3 | 15.0 | 16.6 | 24.3 | 9.1 | 20.0 | 15.2 | 13.6 |
| Percent with diabetes[c] | 5.3 | 13.3 | 13.2 | 13.9 | 15.8 | 10.2 | 11.8 | 13.2 | 10.8 |
| Percent with heart disease[c] | 6.0 | 6.8 | 7.0 | 3.8 | 7.1 | 0.0 | 15.4 | 6.8 | 4.3 |
| HIV rate[d] | 399.9 | NC | 117.0 | 753.0 | 74.6 | 81.7** | 586.4 | 179.6 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 83.8 | 76.8 | 77.1 | 78.7 | 74.0 | 70.8 | 74.6 | 77.1 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 68.4 | 62.3 | 62.9 | 61.0 | 47.5 | 67.9 | 54.7 | 62.5 | 66.5 |
| Percent received flu vaccine[c] | 26.1 | 38.8 | 39.0 | 37.2 | 24.0 | 51.5 | 24.5 | 38.6 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 81.7 per 100,000 population (41 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 50.3 per 100,000 population (1 case).

# Louisiana

## Introduction to Louisiana's Health Equity Activities

Louisiana had an estimated 2016 population of 4,682,000. Blacks/African Americans are the largest racial-ethnic minority population (33 percent), followed by Hispanics/Latinos (5 percent), Asian Americans and NHOPI (2 percent), and American Indians/Alaska Natives (less than 1 percent). Multiracial and persons self-identifying as "other race" comprise 3 percent of the population.[1] Approximately 2,720,000 Louisiana residents live within a primary care health professional shortage area.[2]

The Louisiana Department of Health (LDH) and the Minority Health Affairs Commission established the Louisiana Bureau of Minority Health Access and Promotions (BMHAP) in the late 1990s. The BMHAP addresses public health issues related to minorities and mainly serves five populations: African Americans, Hispanics and Latinos, American Indians, Asians and Pacific Islanders, and economically disadvantaged Whites. Separate from the BMHAP, the Office of Public Health (OPH) lists reducing health disparities among its priorities. The BMHAP has partnered with the OPH to address health concerns such as diabetes and infant mortality and, since 2016, has been a close partner in addressing priorities. A 32-member Minority Health Coalition (MHC)—comprising individuals from federally qualified health centers, health advocates, city council members, and individuals from churches and other community organizations—advises the BMHAP on minority health, health disparities, and health equity.

### Louisiana Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Bureau of Minority Health Access and Promotions |
| Strategic plan in place to address minority health or health equity | Yes |
| Date strategic plan was last updated | 2007 |
| Assessment plan in place to measure progress toward reducing health disparities | No |
| Key strategies used to achieve health equity | • Minority Health Month campaign (April)<br>• Online statewide physical activity and nutrition challenges<br>• Emergency preparedness planning for racial/ethnic communities<br>• Regional infant mortality program |

## Organizational Structure

The BMHAP has an executive director, an outreach coordinator, and a secretary whose primary department is not the BMHAP but who spends 50 percent time on BMHAP initiatives. Beyond these positions, the BMHAP engages a network of volunteers and unpaid interns to help with minority health activities. These volunteers and other collaborations are key to achieving the goals of the BMHAP and the OPH. While no plans exist to increase the number of staff working on minority health and health equity initiatives, three staff members contribute at least half of their time to minority health activities.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/ territorial government | The BMHAP is under the Office of the Secretary |
| SMHE staffing (full-time equivalents) | 3 |
| Advisory committee or panel | Minority Health Coalition |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

## Program Goals and Activities

After Hurricane Katrina in 2005, the BMHAP worked with the Choctaw Tribe (representing some of the residents of affected neighborhoods) to develop the Community Preparedness Response Network, a program for surveying neighborhoods. Door-to-door survey teams noticed that, while minorities might be disproportionately concentrated in neighborhoods with lower socioeconomic status, many economically disadvantaged Whites lived in the same neighborhoods. The BMHAP therefore adjusted its campaigns to serve economically disadvantaged Whites as well as minority populations. As one of the BMHAP's strategies for achieving health equity, the Community Preparedness Response Network aims to help economically disenfranchised and minority populations throughout the state quickly respond and evacuate in the event of future emergencies.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Bureau of Minority Health Access and Promotions | BMHAP |
| Louisiana Department of Health | LDH |
| Office of Public Health | OPH |
| Minority Health Coalition | MHC |

The BMHAP has a standalone strategic plan for minority health, health disparities, and health equity that has been in place since creation of the BMHAP. Prior to Hurricane Katrina, the strategic plan was updated every 5 years. The plan was last updated in 2007, after Hurricane Katrina. At that time, the Community Preparedness Response Network emergency preparedness annual training was integrated into the strategic plan. Although there are evaluations of individual programs, there is no overall assessment plan to measure progress toward reducing health disparities. The OPH also has a 5-year strategic plan that includes reducing health disparities as one of its top five priorities.

The BMHAP primarily sets minority health, health disparities, and health equity priorities in Louisiana with guidance from the MHC and from community leaders and organizations. The MHC is integral to priority setting since its members interact with the communities that the BMHAP serves. The BMHAP has made obesity reduction a priority. Infant mortality reduction is another priority, but it plans to let the OPH lead that effort as part of its plan to reduce disparities. The OPH sets its own minority health, health disparities, and health equity priorities with input from a health summit organized by a partner nonprofit organization, the Louisiana Center for Health Equity.

Several strategies are underway to reduce health disparities, improve minority health, and achieve health equity. One strategy is the Minority Health Month campaign, led by the BMHAP and the MHC since 2016. The BMHAP gives funds to the MHC to distribute to community partners that hold minority health activities such as screenings, workshops, physical activity classes, and health fairs throughout the month of April. Another BMHAP strategy, the Own Your Own Health campaign, is an online physical activity and nutrition tracking system designed for teams of two or more people to see who can accumulate the most miles and lose the most weight. In 2016, 12,000 people signed up to participate. In 2017, the online system allowed for public and private challenges, and the BMHAP included city versus city challenges to see which cities could accumulate the most miles. These challenges focused on 16 cities and 32 schools in minority neighborhoods. The Miss Louisiana Organization partners with the BMHAP to address obesity reduction; each pageant competitor adopts one of the schools and serves as captain for the challenge competition.

A final strategy to improve health equity aims to reduce infant mortality. The BMHAP and the OPH are leading efforts to reduce the number of infant deaths and the number of low birth weight babies. Applying a strategy developed in Arkansas and Oklahoma, the BMHAP leads a community baby shower toolkit effort with help from the OPH and other partners. The toolkit helps communities organize community baby showers, targeting expectant and new mothers in three areas with the highest rates of infant mortality (public health regions 1, 8, and 9). The BMHAP also funds mini-grants to support infant mortality programs in other localities. These efforts primarily serve African American women where infant mortality rates are highest, but also serve Hispanic women. As part of its infant mortality reduction efforts, the OPH leads the Nurse-Family Partnership program that serves all parishes in the state; the program is open to all mothers who qualify but primarily serves African American mothers. The OPH also supports the Parents as Teachers home visiting program in northern Louisiana and oversees the Louisiana Fetal and Infant Mortality Review Network.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Office of Public Health<br>• Amerigroup<br>• Louisiana Primary Care Association<br>• Governor's Council on Physical Fitness and Sports<br>• Southeast Louisiana Area Health Education Center<br>• Pennington Biomedical Research Center |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

With its connections among minority populations, the BMHAP serves as a partner to the OPH in its role of leading efforts to address public health concerns such as diabetes and tobacco control. Working together, the agencies are better able to improve the health of minority communities. The BMHAP has formal contracts with Amerigroup, the Louisiana Primary Care Association, the Governor's Council on Physical Fitness and Sports, the Southeast Louisiana Area Health Education Center, and Pennington Biomedical Research Center. Amerigroup, a managed care organization, sponsors the Own Your Own Health program and the Minority Health Month campaign. This sponsorship allows the BMHAP to provide mini-grants to partners throughout the state. Amerigroup's communications division works closely with the BMHAP to help with outreach. The Louisiana Primary Care Association, which represents all federally qualified health centers in Louisiana, distributes funding for the Minority Health Month campaign and is involved in nearly all BMHAP programs. The Governor's Council on Physical Fitness and Sports is a key partner for addressing obesity, especially among youth and children. The council oversees physical fitness testing, games, and competitions in schools and trains physical education teachers in disadvantaged schools. The Southeast Louisiana Area Health Education Center helps provide training and provides an outreach coordinator for the BMHAP. The outreach coordinator helps with implementation of safeTALK, a program that teaches community members to identify and reduce suicide risk. The Pennington Biomedical Research Center helps measure the outcomes of the Own Your Own Health program, safeTALK, and several physical fitness programs. The BMHAP also partners with individuals in communities; sororities; the Special Supplemental Nutrition Program for Women, Infants, and Children; and the March of Dimes to achieve program goals.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | Approximately $360,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | None |
| Largest funding source | U.S. Office of Minority Health grant |
| Anticipated changes to budget | None |

The total FY 2015 funding for the BMHAP was approximately $360,000. In FY 2015, the largest single source of funding was a U.S. Office of Minority Health grant ($200,000). The other sources of funding were an ongoing Medicaid outreach grant that has been consistent since 2003 ($100,000); an ongoing Centers for Disease Control and Prevention grant that has been consistent since 2004 ($30,000); Amerigroup sponsorship for the Own Your Own Health program ($20,000); and ongoing U.S. Office of Minority Health Region VI funding that has been consistent since 2004 (approximately $10,000). The BMHAP funded approximately $137,000 worth of community grants in FY 2015. Funding from the BMHAP went to support five minority-serving agencies and programs. The largest amount went to the 32-member MHC partners in underserved areas to carry out Minority Health Month activities ($80,000). Funding also went to four Native American tribes in support of the Community Preparedness Response Network strategic goal for emergency preparedness training in the event of infectious disease outbreaks ($30,000); the Growing Up Fit Early Years obesity prevention program at Head Start centers ($15,000); an Asian/Pacific Islander community for a program that assesses mental health as it relates to diabetes ($10,000); and rural parish sheriff departments to obtain the Are You OK? telephone reassurance program for elderly persons, homebound individuals, and latch-key children ($2,000).

# Louisiana

## Louisiana State Data

| Total Population[a]: 4,681,666 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 4.9 | 95.1 | 61.9 | 32.5 | 0.6 | 1.7 | 3.3 | 100.0 | NA |
| Percent of population medically uninsured[a] | 31.0 | 10.0 | 9.1 | 13.0 | 18.5 | 11.3 | 25.2 | 11.0 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 7.7 | 5.4 | 11.0 | SP | SP | NC | 7.6 | 5.9 |
| Age-adjusted mortality rate[b] | 394.0 | 885.3 | 828.5 | 996.4 | 348.9 | 361.8 | NC | 870.5 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 11.8 | 14.4 | 12.4 | 18.5 | 17.2 | 5.8 | 14.4 | 14.4 | 13.6 |
| Percent with diabetes[c] | 8.5 | 12.4 | 11.2 | 14.0 | 25.8 | 9.0 | 6.5 | 12.2 | 10.8 |
| Percent with heart disease[c] | 1.6 | 6.0 | 6.5 | 4.8 | 5.0 | 3.0 | 5.4 | 5.9 | 4.3 |
| HIV rate[d] | 500.0 | NC | 207.3 | 1107.4 | 126.2 | 98.4** | 845.3 | 504.7 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 59.0 | 73.5 | 71.3 | 78.2 | 62.5 | 46.3 | 48.8 | 72.5 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 60.5 | 57.0 | 61.9 | 48.3 | 45.5 | 58.8 | 40.2 | 56.8 | 66.5 |
| Percent received flu vaccine[c] | 14.2 | 34.1 | 34.6 | 30.4 | 37.9 | 35.6 | 26.8 | 33.1 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

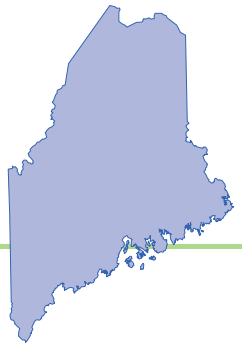
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 98.4 per 100,000 population (67 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 367.9 per 100,000 population (6 cases).

# Maine



## Introduction to Maine's Health Equity Activities

Maine had an estimated 2016 population of 1,331,000 and its racial-ethnic minority populations include: Blacks/African Americans (2 percent), Hispanics/Latinos (2 percent), American Indians/Alaska Natives (1 percent), and Asian Americans and NHOPI (1 percent). Persons self-identifying as multiracial or "other race" comprise 2 percent of the population.[1] Approximately 85,000 Maine residents live within a primary care health professional shortage area.[2]

Housed within the Maine Department of Health and Human Services, the Maine Center for Disease Control and Prevention (MCDC) is comprised of five divisions, each of which addresses health equity. The MCDC's mission is "to provide the leadership, expertise, information and tools to assure conditions in which all Maine people can be healthy."[3]

### Maine Minority Health Overview

| | |
|---|---|
| Name of state/territorial minority health entity | Maine's Office of Health Equity closed in early 2016 and responsibilities transferred to the MCDC. |
| Strategic plan in place to address minority health or health equity | Information on the Maine Center for Disease Control and Prevention's strategic plan for minority health and health equity is documented in *Healthy Maine 2020*. |
| Date strategic plan was last updated | 2015 |
| Assessment plan in place to measure progress toward reducing health disparities | The *Shared Community Health Needs Assessment* includes data evaluations that will guide future actions. |
| Key strategies used to achieve health equity | • Improving health disparity data<br>• Refining Behavioral Risk Factor Surveillance Survey questions, and increasing sample size<br>• Coordinating with partners to improve population-specific needs assessments<br>• Improving access to sexual assault support for lesbian, gay, bisexual, and transgender individuals<br>• Developing geographically specific priorities and strategies |

## Organizational Structure

The MCDC, housed within the Maine Department of Health and Human Services, does not have a committee or panel that advises on minority health or health equity. One MCDC staff member, an accreditation and performance improvement manager, devotes approximately 30 percent time to health disparities and health equity. The MCDC does not have volunteers or interns, and does not anticipate changes in staff allocations.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | N/A |
| SMHE staffing (full-time equivalents) | N/A |
| Advisory committee or panel | None |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 Maine Center for Disease Control & Prevention. About Us. Available at the Maine MCDC website. Last accessed 8/21/2017.

## Program Goals and Activities

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Maine Center for Disease Control and Prevention | MCDC |

*Healthy Maine 2020* is a publicly available MCDC publication intended to help with planning, reporting, and responding to Maine's public health issues. As one of its goals, *Healthy Maine 2020* aims to "achieve health equity, eliminate disparities, and improve the health of all groups."[4] Additionally, *Maine's Shared Community Health Needs Assessment* was updated November 18, 2015, replacing the 2012 State Health Assessment.

Much of the MCDC's efforts toward reducing disparities and achieving health equity involve partnerships and collaborations with various organizations. For example, the MCDC worked with two firms (Market Decisions Research and Hart Consulting) to develop the *2015 Shared Community Health Needs Assessment*, which was developed through the Maine Shared Health Needs Assessment and Planning Process. That process, which represents a collaboration between the MCDC, Central Maine Healthcare, Eastern Maine Healthcare Systems, Maine General Health, and MaineHealth, seeks to "turn data into action" and implement comprehensive health improvement strategies.[5] The *2016 Needs Assessment* informs priority setting by setting health disparities reduction goals for each MCDC division.

Strategies implemented across the MCDC to improve minority health include improving health disparity data collection and analysis. For example, the MCDC is working with the University of Southern Maine to conduct an assessment of all relevant and available data sources. It is also coordinating with partners to improve population-specific needs assessments, such as enhancing access to sexual assault support for lesbian, gay, bisexual, and transgender (LGBT) individuals. The MCDC also participates in the BRFSS, a telephone survey that tracks risk behaviors and health conditions throughout the United States, and has added two questions about gender identity to the BRFSS that will enhance knowledge of the state's LGBT population. Additionally, the MCDC is providing resources for a larger sample size per county to improve the reliability of BRFSS subpopulation analyses.

While not guided by legislative mandates to set priorities for health equity, the MCDC Division of Public Health Systems works with nine legislatively mandated public health districts (eight geographic districts and one tribal district) to reduce health disparities.[6] Geographically-specific priorities and strategies, therefore, have been another focus of MCDC's health equity activities. Specifically, District Public Health Improvement Plans, a product of a MCDC collaboration with public health districts, provide geographically-tailored plans to meet needs of the state's minorities, many of whom are clustered in particular regions of the state. Such plans also help target disparities reduction efforts with Maine's federally recognized tribal entities.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Catholic Charities<br>• City of Portland<br>• Maine Access Foundation<br>• Maine Coalition Against Sexual Assault<br>• Tribal Health District<br>• University of Southern Maine |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

The MCDC had formally contracted with the University of Southern Maine to assess available public health data sets—such as vital statistics, hospital discharge data, and census data—to determine their reliability, limitations, and potential as new data sources for particular populations. The assessment examined data by race, ethnicity, sexual orientation, gender identity, income, age, and gender and has produced recommendations to improve health disparity data. Implementation of those recommendations has been a focus of MCDC efforts (see Program Goals and Activities section, above).

4 *Healthy Maine 2020*. Available at the Maine Center for Disease Control and Prevention website. Last accessed 8/21/2017.

5 Maine Shared Health Needs Assessment & Planning Process. 2015 Shared Community Health Needs Assessment. Available on the public health data page within MCDC's website. Last accessed 8/21/2017.

6 Bureau of Indian Affairs. Tribal Leaders Directory. Available through the U.S. Department of the Interior's Bureau of Indian Affairs' website. Last accessed 8/21/2017.

Additionally, the MCDC has coordinated with a range of partners to improve population-specific needs assessments. One community partner, for example, conducted a survey focused on immigrants in Lewiston and Auburn. MCDC collaborators in the needs assessments effort include the City of Portland, federally recognized tribal entities, Catholic Charities, and the Maine Access Foundation.

The MCDC formally contracts with the Maine Coalition Against Sexual Assault to increase cultural competency of sexual assault agencies regarding LGBT communities. To support this work, the MCDC is developing partnerships with LGBT advocacy organizations and sexual assault agencies.

Finally, the MCDC formally contracts with several nongovernmental organizations to reduce health disparities. One such formal collaboration is with the Tribal Health District, which is governed by the four Maine tribes (the Penobscot, Passamaquoddy, Micmac, and Maliseet, collectively known as Wabanaki). Together, the MCDC and the Tribal Health District set priorities and seek to improve public health by implementing District Public Health Improvement Plans.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $1,330,928 |
| Annual budget (FY 2015) of SMHE from state/territorial government | Zero |
| Largest funding source | Federal |
| Anticipated changes to budget | None |

The FY 2015 funding for MCDC minority health activities was $1,330,928. The MCDC receives funding for minority health activities from a Preventive Health and Health Services Block Grant from the U.S. Centers for Disease Control and Prevention.[7] The MCDC funds nongovernment organizations, including the University of Southern Maine ($99,822) and the Maine Coalition Against Sexual Assault ($110,605). The MCDC does not anticipate funding changes in the next 2 years.

7 U.S. Centers for Disease Control and Prevention Services. PHHS Block Grant Contacts Available on the PHHS webpage within the federal MCDC's website. Last accessed 8/21/2017.

# Maine

## Maine State Data

| Total Population[a]: 1,331,479 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 1.5 | 98.5 | 94.5 | 1.7 | 0.6 | 1.3 | 2.1 | 100.0 | NA |
| Percent of population medically uninsured[a] | 14.9 | 7.8 | 7.8 | 14.6 | 14.1 | 3.1 | 10.0 | 7.9 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 6.3 | 6.4 | SP | SP | SP | NC | 6.6 | 5.9 |
| Age-adjusted mortality rate[b] | 272.1 | 760.9 | 762.8 | 496.2 | 819.7 | 257.6 | NC | 759.0 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 8.1 | 16.7 | 16.4 | 8.7 | 23.1 | 21.2 | 31.3 | 16.7 | 13.6 |
| Percent with diabetes[c] | 6.4 | 10.6 | 10.5 | 3.6 | 14.5 | 0.8 | 16.5 | 10.5 | 10.8 |
| Percent with heart disease[c] | 5.0 | 5.2 | 5.2 | 0.7 | 10.3 | 0.8 | 5.8 | 5.2 | 4.3 |
| HIV rate[d] | 625.4 | NC | 103.9 | 1458.4 | 84.9 | 44.9** | 316.9 | 128.5 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 73.5 | 73.2 | 73.4 | 68.4 | 61.9 | 62.6 | 71.0 | 73.1 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 71.1 | 63.6 | 64.1 | 51.9 | 42.8 | 65.7 | 53.0 | 63.6 | 66.5 |
| Percent received flu vaccine[c] | 35.7 | 41.7 | 41.8 | 54.0 | 29.5 | 54.4 | 27.2 | 41.5 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

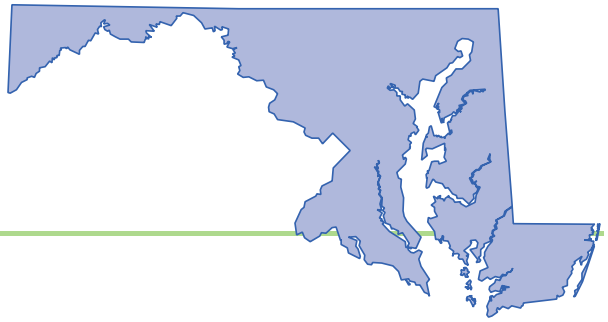
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 44.9 per 100,000 population (6 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 314.5 per 100,000 population (1 case).

# Maryland



## Introduction to Maryland's Health Equity Activities

Maryland had a 2016 population of 6,016,000. Blacks/African Americans (30 percent) are the largest racial-ethnic minority population, followed by Hispanics/Latinos (10 percent), Asian Americans and NHOPI (6 percent), and American Indians/Alaska Natives (0.2 percent). Persons self-identifying as multiracial or "other race" comprise 7 percent of the population.[1] Approximately 1,178,000 Maryland residents live within a primary care health professional shortage area.[2]

In 2004, state legislation created the Office of Minority Health and Health Disparities (MHHD) within the Maryland Department of Health and Mental Hygiene (DHMH).[3] The MHHD focuses on vulnerable populations and populations that experience health disparities.

### Maryland Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Department of Health and Mental Hygiene, Office of Minority Health and Health Disparities |
| Strategic plan in place to address minority health or health equity | Yes. The Office of Minority Health and Health Disparities annually updates its strategic plan, aligning it with the annually-updated Department of Health and Mental Hygiene's strategic plan. |
| Date strategic plan was last updated | The Office of Minority Health and Health Disparities strategic plan is currently being updated; it was last updated in 2016. |
| Assessment plan in place to measure progress toward reducing health disparities | The Office of Minority Health and Health Disparities strategic plan will include an assessment plan with specific objectives and goals. |
| Key strategies used to achieve health equity | • Build community capacity<br>• Address health in all policies<br>• Increase understanding of what creates health |

## Organizational Structure

The director of the MHHD reports to the Maryland Secretary of Health and Mental Hygiene and has relationships across all departments within the DHMH. The Minority Outreach and Technical Assistance grantees serve as advisors to the MHHD.

In total, the MHHD has nine full-time staff that devote 100 percent time to MHHD activities and one staff member who devotes 75 percent time to MHHD activities. Full-time staff include a program director, a deputy director, a senior program manager, two program administrators, a program specialist (contractual), a data analyst (contractual), an executive assistant, and a secretary. A health equity manager position is vacant. The MHHD also has a structured unpaid internship program that is competitive nationwide.

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 Maryland General Assembly (2004). HB 86/SB 177.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The MHHD is housed within the Maryland Department of Health and Mental Hygiene |
| SMHE staffing (full-time equivalents) | 9 |
| Advisory committee or panel | Minority Outreach and Technical Assistance grantees serve as advisors to the MHHD |

## Program Goals and Activities

In January 2017, under a new Maryland Secretary of Health and Mental Hygiene, the DHMH was developing an updated strategic plan to align with new and/or evolving priorities. At that time, the MHHD also was conducting its annual strategic plan update to ensure continued alignment with the Department's plan; the MHHD plan was expected to be completed in the spring of 2017. Most recently updated in 2016, the MHHD plan includes an assessment strategy with performance metrics and specific objectives. The MHHD sets priorities through a data-driven process that includes feedback from localities, as well as priorities established by state legislation (e.g., requirements to focus on specific health disparities).

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Maryland State Department of Health and Mental Hygiene | DHMH |
| Office of Minority Health and Health Disparities | MHHD |

One MHHD disparities reduction strategy is to strengthen community capacity by funding 16 Minority Outreach and Technical Assistance grantees to develop and implement community-based health equity programs. Grantee organizations receive technical assistance and training from MHHD to sustain funding and programs in local communities. Technical assistance includes webinars on such topics as data collection and reporting, evaluation, and grant writing. Minority Outreach and Technical Assistance grantees use community-based engagement and implement evidence-based interventions based on needs assessments. They also work with partners to build organizational capacity and provide feedback from Maryland's localities to help set MHHD priorities. The MHHD provides connections to DHMH public health programs, such as the Environmental Health Bureau and the Center for HIV Prevention and Health Services, to provide support and access to additional resources to strength grantee capacity and foster collaboration.

The MHHD also builds multisector collaborations through partnerships with both state agencies and nongovernmental entities to reduce health disparities. For instance, it leads a Health and Homelessness Workgroup and participates in the Maryland Interagency Council on Homelessness. Together with other agencies, the MHHD is also applying for a grant from the Centers for Medicare and Medicaid Services to address specific health disparities.

In addition, the MHHD seeks to increase understanding of the factors that drive health disparities and, likewise, build awareness of what creates health. It does so by conducting education programs on health equity, social determinants of health, and cultural and linguistic competence. Minority Outreach and Technical Assistance grantees participate by conducting health fairs, seminars, and other informative programs. Other educational efforts planned by the MHHD include educating staff within the state's federally qualified health centers and members of various state boards and commissions. The MHHD is also partnering with academic institutions to deploy educational programming around "what creates health in the community." Finally, the MHHD also works with in-state universities to recruit for its internship program.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Center for HIV Prevention and Health Services<br>• Environmental Health Bureau<br>• Morgan State University<br>• Mary's Center (federally qualified health center)<br>• Associated Black Charities<br>• Asian American Center of Frederick<br>• Maryland Department of Human Resources |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

The MHHD works with agencies and nongovernmental partners, particularly workgroups and advisory groups, to address health disparities. Such partners include: the Maryland Interagency Council on Homelessness, the Health and Homelessness workgroup, a Governor's Office for Children's workgroup on youth and homelessness, an advisory group for a grant regarding disabilities that the DHMH Center for Chronic Disease Prevention and Control received from the U.S. Centers for Disease Control and Prevention, and a rural health workgroup on workforce development and vulnerable populations. The MHHD also leads an advisory group to engage stakeholders to develop strategies for developing Maryland's community health workforce. Such activities are informal and do not involve memoranda of understanding.

Building capacity is another focus of the MHHD. It does so through collaborations with such agencies as the Environmental Health Bureau, which provides funding to the Minority Outreach and Technical Assistance grantees to address the effects of climate change. The MHHD also partners with the Center for HIV Prevention and Health Services to provide additional funding for the Minority Outreach and Technical Assistance grantees to enhance their capacity to provide HIV-related outreach and education. Maryland Medicaid, the Maryland Department of the Environment, and the Maryland Department of Housing and Community Development are among other state governmental organizations with which the MHDH partners to support priority issues at the community level.

Morgan State University and Mary's Center, a federally qualified health center, also collaborate with the MHHD through a State Partnership Grant from the U.S. Office of Minority Health. In ZIP codes with high uninsured and minority populations, the MHHD has a formal contract with Mary's Center to increase access to primary care services and reduce both emergency department visits and hospital readmissions by leveraging community health workers. Through a memorandum of understanding (MOU), the MHHD also works with one of the Minority Outreach and Technical Assistance grantees, Associated Black Charities, which has been implementing a community health worker intervention in Dorchester County. The Asian American Center of Frederick, one of the Minority Outreach and Technical Assistance grantees, partners with the MHHD via an MOU as well.

The MHHD works with other offices and agencies, such as local health departments, academic institutions, and the Maryland Department of Human Resources to prioritize heath disparities efforts. For example, in an effort to address the needs of the state's homeless population, the MHHD and several other agencies (including the state Departments of Human Resources, Transportation, Housing and Community Development, Public Safety and Correctional Services, and the larger DHMH) collaborate through the Maryland Interagency Council on Homelessness to develop a statewide plan. At this time, the MHHD leads the Council's Health and Homelessness Workgroup, which is conducting assessments and developing strategies to address health needs of the homeless population.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $2,222,455 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $2,092,455 |
| Largest funding source | State government |
| Anticipated changes to budget | Possible |

Total FY 2015 funding for the MHHD was $2,222,455, comprising allocations from two sources: the State of Maryland ($2,092,455) and the U.S. Office of Minority Health ($130,000). State funding may be adjusted on an annual basis. Funding from the U.S. Office of Minority Health includes a State Partnership Grant that supports the MHHD collaborations with Mary's Center and Morgan State University.

The MHHD received three cycles of funding from the U.S. Office of Minority Health from 2005 to 2015, totaling more than $1.5 million. In addition, in 2015, the MHHD provided state general funding to nongovernmental community-based organizations in 12 jurisdictions that have the highest proportion of minorities. That funding was earmarked for implementing health disparities programs to improve birth outcomes, reduce cardiovascular disease morality, improve flu vaccination rates, increase health awareness, and provide education and outreach within minority populations. In FY 2015, the MHHD provided a total of $550,000 to nongovernmental entities. As noted earlier, the MHHD funds 16 Minority Outreach and Technical Assistance grantees to address local health disparities.

# Maryland

## Maryland State Data

| Total Population[a]: 6,016,447 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 9.8 | 90.3 | 56.4 | 29.9 | 0.2 | 6.3 | 7.2 | 100.0 | NA |
| Percent of population medically uninsured[a] | 21.3 | 4.7 | 4.9 | 6.4 | 11.0 | 5.3 | 17.7 | 6.3 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 5.4 | 6.7 | 4.3 | 10.8 | SP | 5.3 | NC | 6.6 | 5.9 |
| Age-adjusted mortality rate[b] | 339.9 | 734.9 | 706.4 | 814.7 | 235.3 | 337.3 | NC | 717.6 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 8.1 | 14.6 | 13.5 | 16.8 | 20.9 | 7.8 | 13.5 | 14.1 | 13.6 |
| Percent with diabetes[c] | 8.1 | 11.0 | 9.8 | 13.9 | 9.7 | 6.3 | 9.0 | 10.8 | 10.8 |
| Percent with heart disease[c] | 2.5 | 3.9 | 4.6 | 2.9 | 3.5 | 1.1 | 4.3 | 3.8 | 4.3 |
| HIV rate[d] | 511.7 | NC | 163.1 | 163.1 | 144.8 | 64.3** | 2340.3 | 657.8 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 69.5 | 76.7 | 74.5 | 82.4 | 77.1 | 68.9 | 69.0 | 76.3 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 58.5 | 70.5 | 73.7 | 64.3 | 60.2 | 69.5 | 59.1 | 69.9 | 66.5 |
| Percent received flu vaccine[c] | 30.3 | 44.4 | 48.6 | 35.4 | 34.6 | 44.3 | 30.5 | 43.5 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

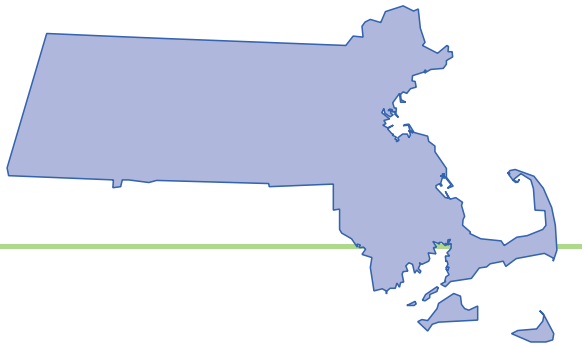
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 64.3 per 100,000 population (205 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 161.0 per 100,000 population (4 cases).

# Massachusetts



## Introduction to Massachusetts' Health Equity Activities

Massachusetts had an estimated 2016 population of 6,812,000. Hispanics/Latinos are the largest racial-ethnic minority population (12 percent), followed by Blacks/African Americans (8 percent), Asian Americans and NHOPI (7 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 7 percent of the population.[1] Approximately 539,000 Massachusetts residents live within a primary care health professional shortage area.[2]

The Massachusetts Department of Public Health (MDPH) promotes the health and well-being of all residents by ensuring access to high-quality public health and health care services, and by focusing on prevention, wellness and health equity. MDPH's Office of Health Equity (OHE) serves as an agency-wide resource, providing technical assistance to MDPH programs, and promoting principles and policies to inform the way health services are designed and delivered, in order to address health inequities.

### Massachusetts Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Massachusetts Department of Public Health, Office of Health Equity |
| Strategic plan in place to address minority health or health equity | A strategic plan with a specific focus on minority health or health equity is not available. The *Massachusetts Department of Public Health Strategic Plan 2014-2016*[3] includes strategies for addressing health disparities in minority populations as part of the larger goal of improving health for all. In the fall of 2017, the Office of Health Equity was incorporated into a broader Office of Population Health and MDPH will be developing a new plan to address health equity. |
| Date strategic plan was last updated | 2014 |
| Assessment plan in place to measure progress toward reducing health disparities | The Massachusetts Department of Public Health (MDPH) Strategic Plan 2014-2016 includes measurable objectives for each standard outlined in the plan. The MDPH recently established a quality improvement office responsible for monitoring progress based on the plan. MDPH's mission statement specifically states "promoting health equity" by addressing data, disparities, and determinants. |
| Key strategies used to achieve health equity | • Agency-wide data collection standards<br>• Contractual requirements for health providers to meet Culturally and Linguistically Appropriate Services (CLAS) National Standards<br>• Health care interpreter services to monitor and support language access planning and practice<br>• Oral Health Equity Project to increase the number of children age 0–14 who see the dentist every year<br>• Health and Disabilities Program for public health policy/systems change to improve the health of people with disabilities |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 Massachusetts Department of Public Health Strategic Plan 2014-2016.

## Organizational Structure

The OHE was established to address health disparities and minority health issues in Massachusetts and provides support to MDPH bureaus and programs. It also convenes internal advisory workgroups for specific initiatives.

The OHE has seven staff members in total. Five of its staff members dedicate 100 percent of their time to health equity initiatives, including the office's director, the deputy director, three program coordinators, and one support specialist. Two staff members split time between OHE and other MDPH units: the coordinator for the Oral Health Project and an epidemiologist dedicate, respectively, 50 percent and 35 percent time exclusively on minority health initiatives through the OHE. In addition, the OHE also hires a dental consultant and occasionally engages interns hired though the Massachusetts Commission for the Blind as well as graduate students through various schools of public health to help with its activities.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Office of Health Equity is housed within the Massachusetts Department of Public Health. |
| SMHE staffing (full-time equivalents) | 7 |
| Advisory committee or panel | Yes |

## Program Goals and Activities

The MDPH, as part of its 2014–2016 strategic plan, has adopted a crosscutting approach to promoting health equity and reducing disparities in which each MDPH bureau and program shares responsibility for these goals. The MDPH has created a Racial Equity Leadership Team (RELT) to lead this work across the agency, with the goal of embedding health equity into all areas and levels of the organization rather than relegated to a siloed office. In addition, to oversee both the data and health equity teams a new Assistant Commissioner for Population Health position was created. This will facilitate collaboration and leverage both teams in support of key priorities. In recent years, the MDPH has made substantial progress in identifying priority areas related to health equity, and the office is still the lead in these specific areas. For example, the OHE has procured federal grants to fund such activities as priority setting and establishing community advisory boards to provide OHE with input on a range of specific topics. In turn, the OHE advises MDPH's bureaus on how to use data to guide decisions, prioritize efforts and, more generally, operationalize promoting health equity in the context of ongoing activities.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Massachusetts Department of Public Health | MDPH |
| Office of Health Equity | OHE |

The OHE is also leading the Health and Disabilities Program, another strategy that promotes public health policy and systems change to improve the health of people with disabilities. Funded through a U.S. Centers for Disease Control and Prevention grant, this effort prioritizes health issues such as physical activity, targeting people with mobility limitations or intellectual disabilities. One activity, an 8-week diabetes health management program, is a collaborative effort between the OHE and the Massachusetts Department of Veterans' Services. The OHE is collaborating with "Mass in Motion," a MDPH program that promotes healthy eating and physical activity. The OHE also supports the Health and Disability Partnership, a coalition of disability advocacy organizations, state agencies, and other stakeholders working to improve the health of people with disabilities in Massachusetts.

Among the many related endeavors sponsored by the OHE is an initiative to establish agency-wide standards for data collection. Race, Ethnicity and Language (REaL) data collection standards were produced in 2015 in collaboration with the former Bureau of Health Information, now the Office of Data Management, and are posted online. Such standardization aims to improve the quality of data used to identify disparities and, as a result, better inform equity-related policy and program development. All MDPH bureaus collect these data for their programs and services, which contribute to approximately 300 separate datasets. Training on the REaL data collection standards was developed and delivered to staff responsible for data collection by the Bureau of Health information in 2014. In 2016, the OHE led MDPH's efforts to develop sexual orientation and gender identity data collection standards, which are posted online. It conducted this work in collaboration with the Office of Data Management and staff from across MDPH bureaus, including the Office of HIV/AIDS, which provided funding for a consultant to draft

the standards. Current efforts include standardizing data collection on housing stability and homelessness across MDPH programs and future efforts include standardizing data collection on disability status.

Another strategy to achieve health equity is the OHE's decade-long leadership in the MDPH Culturally and Linguistically Appropriate Services (CLAS) Initiative. Specifically, the OHE has been working to implement the National CLAS Standards within MDPH programs and among vendors who receive direct service grants from the MDPH. The OHE provides ongoing training to educate MDPH staff on the National CLAS Standards and ensure that they are built into all MDPH bureaus' procurement policies, vendor service delivery, and methods by which contract managers evaluate and monitor the work of vendors. In addition, the OHE conducts trainings for MDPH contract managers and vendors on materials it has developed, including a National CLAS Standards manual and self-assessment tool for vendors, as well as an annual internal assessment to monitor the MDPH's progress in meeting the standards. The OHE developed CLAS-related materials to aid in the implementation and ongoing assessment of implementation efforts, including the Making CLAS Happen Manual, the CLAS Self-Assessment Tool for Providers, and the CLAS Internal Assessment for Public Health Agencies, all of which have been shared widely with other state offices of minority health.

Improving patient-provider communication is another core equity strategy for the OHE. To ensure access to medical interpretation and health communication, health care facilities across the state are implementing national and statewide requirements to deliver interpreter services to individuals with limited English proficiency. The OHE collaborates with the MDPH Bureau of Health Care Safety and Quality, as well as health care facilities, to monitor language access service access. It also reviews and advises on regulations—for example, the OHE recently sought to expand statewide interpretation services to include sign language.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Massachusetts Department of Public Health: Office of Oral Health; Office of Local and Regional Health; Early Intervention Program; Women, Infants and Children (WIC) Nutrition Program<br>• Massachusetts Department of Veterans' Services<br>• Health and Disability Partnership<br>• Brandeis University<br>• Worcester Public Schools<br>• Holyoke Public Schools<br>• Family Health Center of Worcester |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

Many of the programs and projects undertaken by the OHE depend in large part on external help. To that end, the OHE partners with many governmental and nongovernmental organizations in its effort to eliminate health disparities and advance health equity in Massachusetts. For example, to implement the Oral Health Equity Project described above, the OHE established formal contracts with local government and community organizations—including Worcester Public Schools, Holyoke Public Schools, the Family Health Center of Worcester, and Holyoke Health Center. The OHE also has a formal contract with Brandeis University, which provides evaluation consulting for its Health and Disability Program.

The OHE also collaborates with a variety of MDPH offices and programs, including the Office of Oral Health, the Office of Local and Regional Health, the Early Intervention Program, and the Women, Infants and Children (WIC) Nutrition Program. It also partners with the Massachusetts Department of Veterans' Services on health equity initiatives for the Health and Disability Program.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $690,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $130,000 |
| Largest funding source | Federal government |

The total FY 2015 funding for the OHE was $690,000. In FY 2015, the office had four funding sources: the Commonwealth of Massachusetts ($130,000) and three federal grants. Specifically, the OHE received a grant of $300,000 from the U.S. Centers for Disease Control and Prevention to support its Health and Disability Program. It also received a State Partnership Grant Program for the CLAS initiative from the U.S. Office of Minority Health ($150,000) and a Maternal and Child Health Services Block Grant to support such activities as the health care interpreter services ($110,000). Funding is expected to remain relatively stable in future years.

The OHE has provided funding to local governmental organizations in Massachusetts. For example, in 2015, 10 local boards of health in Massachusetts received funding from the OHE to participate in the Immunization Equity Initiative, an effort aimed at reducing disparities in immunization rates among racial, ethnic, and linguistic populations in Massachusetts. In FY 2016 and FY 2017, the OHE provided funding to community partners in Worcester and Holyoke as part of its Oral Health Equity Project. This will continue in FY 2018 and FY 2019. In FY 2018, the OHE will also provide funding to three Mass in Motion communities to enhance/adapt for people with disabilities the work they do to promote opportunities for healthy eating and active living in the places people live.

# Massachusetts

## Massachusetts State Data

| Total Population[a]: 6,811,885 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 11.5 | 88.5 | 78.7 | 7.5 | 0.2 | 6.5 | 7.2 | 100.0 | NA |
| Percent of population medically uninsured[a] | 4.9 | 2.2 | 2.1 | 4.1 | 9.9 | 3.2 | 4.8 | 2.5 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 6.4 | 3.8 | 3.8 | 8.6 | SP | SP | NC | 4.3 | 5.9 |
| Age-adjusted mortality rate[b] | 466.0 | 662.3 | 690.7 | 604.8 | 330.5 | 317.3 | NC | 669.0 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 16.4 | 15.1 | 15.0 | 19.4 | 23.1 | 13.0 | 16.9 | 15.3 | 13.6 |
| Percent with diabetes[c] | 9.8 | 9.2 | 8.9 | 13.7 | 21.6 | 5.5 | 9.6 | 9.1 | 10.8 |
| Percent with heart disease[c] | 2.5 | 4.2 | 4.5 | 2.4 | 4.5 | 0.6 | 3.8 | 4.0 | 4.3 |
| HIV rate[d] | 899.8 | NC | 181.8 | 1474.1 | 233.3 | 103.4** | 480.8 | 338.4 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 78.2 | 79.2 | 79.7 | 82.9 | 75.2 | 73.7 | 74.2 | 79.3 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 69.7 | 75.0 | 76.3 | 66.1 | 49.4 | 71.3 | 67.6 | 74.7 | 66.5 |
| Percent received flu vaccine[c] | 36.5 | 42.6 | 43.5 | 37.5 | 29.9 | 34.6 | 3.1 | 42.1 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

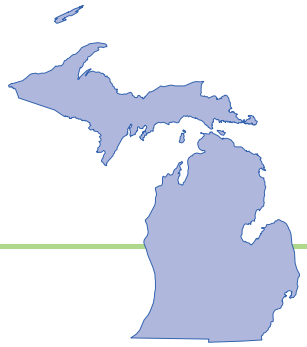
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 103.4 per 100,000 population (379 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 175.7 per 100,000 population (4 cases).

# Michigan



## Introduction to Michigan's Health Equity Activities

Michigan had an estimated 2016 population of 9,928,000. Blacks/African Americans are the largest racial-ethnic minority population (14 percent), followed by Hispanics/Latinos (5 percent), Asian Americans and NHOPI (3 percent), and American Indians/Alaska Natives (1 percent). Persons self-identifying as multiracial or "other race" comprise 4 percent of the population.[1] Approximately 2,194,000 Michigan residents live within a primary care health professional shortage area.[2]

In 2004, the Health Disparities Reduction and Minority Health Section (HDRMHS) replaced the Michigan Department of Health and Human Services (MDHHS) Office of Minority Health. In 2007, Public Act 653 required the MDHHS to establish strategic plans, policies, and structures to address health disparities. The HDRMHS serves as the coordinating body within the MDHHS to address health disparities. Its mission is to "provide a persistent and continuing focus on assuring health equity and eliminating health disparities among Michigan's populations of color."[3]

### Michigan Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Michigan Department of Health and Human Services, Health Disparities Reduction and Minority Health Section |
| Strategic plan in place to address minority health or health equity | *Michigan Health Equity Roadmap*[4] |
| Date strategic plan was last updated | 2010 |
| Assessment plan in place to measure progress toward reducing health disparities | The Health Disparities Reduction and Minority Health Section provides an annual report to the Michigan legislature on the status of minority health in Michigan. |
| Key strategies used to achieve health equity | • Improving race/ethnicity data collection, data systems, and data accessibility<br>• Promoting and sustaining effective partnerships and programs<br>• Promoting public education and awareness related to social justice and the social determinants of health<br>• Ensuring equitable access to quality health care<br>• Strengthening community engagement, capacity, and empowerment |

## Organizational Structure

The Michigan Department of Health and Human Services' Health Disparities Reduction and Minority Health Section has been coordinating departmental health equity activities since its establishment in 2004. It was moved in 2013 and is now housed within the MDHHS Policy, Planning, and Legislative Services Administration to reflect the Department's recognition of health equity as a crosscutting issue. Although the HDRMHS itself does not have a formal advisory body, the MDHHS's internal Health Equity Steering Committee is a staff resource on equity-

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 Michigan Department of Health and Human Services. Health Disparities Reduction and Minority Health Section (HDRMHS) website. Last accessed 8/2/2017.

4 Michigan Health Equity Roadmap: A vision and framework for improving the social and health status of racial and ethnic populations in Michigan. Published in February 2010 by the Michigan Department of Community Health, Division of Health, Wellness and Disease Control, Health Disparities Reduction and Minority Health Section (HDRMHS). Available on the HDRMHS website. Last accessed 8/2/2017.

related issues and, occasionally, serves in an advisory capacity for the HDRMHS.

The HDRMHS has four full-time staff members who devote 100 percent of their time to minority health initiatives: a section manager, a program specialist, a program coordinator, and a training coordinator. Many other MDHHS staff, including an equity coordinator and an epidemiologist from the MDHHS Maternal Child Health Epidemiology Section, also dedicate time to health equity activities.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Health Disparities Reduction and Minority Health Section is housed within the Michigan Department of Health and Human Services. |
| SMHE staffing (full-time equivalents) | 4 |
| Advisory committee or panel | The MDHHS Health Equity Steering Committee occasionally works in an advisory capacity for the HDRMHS. |

## Program Goals and Activities

In 2010, the HDRMHS released the *Michigan Health Equity Roadmap ("Roadmap")*, which outlines a vision and recommended strategies for reducing health disparities in Michigan. The *Roadmap* identifies five overarching priority areas:

1. Race/ethnicity data
2. Government and community capacity
3. Social determinants of health
4. Access to quality health care
5. Community engagement and empowerment

The HDRMHS aligns minority health priorities with the priority areas identified in the *Roadmap*. It also relies on input from community groups, data, and research to guide decision-making. To track progress toward reducing health disparities, the HDRMHS delivers an annual health equity report to the Michigan legislature documenting MDHHS efforts to advance health equity. The HDRMHS also releases data reports to monitor progress toward improving minority health and reducing health disparities. The *Roadmap*, health equity reports, and data reports are publicly available online.[5]

HDRMHS strategies to reduce health disparities and improve minority health align with the five priority areas identified in the *Roadmap*. One of those strategies is to improve race and ethnicity data collection, data systems, and data accessibility. To support that strategy, the HDRMHS helps fund standalone behavioral risk factor surveys on specific racial/ethnic populations in Michigan. These surveys capture data on racial and ethnic populations that are too small to be accurately represented by statewide Behavioral Risk Factor Surveillance System (BRFSS) surveys. The HDRMHS also leads the Michigan Health Equity Data Project, which monitors health equity by gathering data for five of Michigan's racial and ethnic minority populations and combining it into a single data set. Every 2 years, the HDRMHS updates the data set and releases data briefs as part of its annual report to the legislature.

Another strategy of the HDRMHS is to promote and sustain effective partnerships and programs by strengthening the capacity of local communities to address health disparities. This aligns with the second priority area identified in the *Roadmap*: developing government and community capacity. Specifically, the HDRMHS established a program to assist local organizations in assessing community needs and designing appropriate interventions. Community groups can apply to the HDRMHS for small grants to support these activities and may participate in HDRMHS-led trainings to secure future funding.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Health Disparities Reduction and Minority Health Section | HDRMHS |
| Michigan Department of Health and Human Services | MDHHS |

In a third strategy, the HDRMHS promotes public education and awareness related to social justice and the social determinants of health. The HDRMHS facilitates workshops for MDHHS staff and partners on the National Standards for Culturally and Linguisti-

5 All of these reports are available on the Health Disparities Reduction and Minority Health Section (HDRMHS) website. Last accessed 8/2/2017.

cally Appropriate Services in Health and Health Care (National CLAS Standards). It also developed and launched an online health equity training module in 2017. Open to MDHHS staff, contractors, and the public, this module provides an overview of the issues and describes how to view public health activities through a health equity lens. The HDRMHS also developed a health equity toolkit, publicly available on the HDRMHS's website, designed for external organizations to promote awareness about the social, economic, and environmental factors that contribute to health.

The HDRMHS's fourth strategy is to lead and participate in activities to ensure equitable access to quality health care. Some of the activities are funded through Michigan's State Innovation Model Test grant from the Center for Medicare & Medicaid Innovation, as well as other grants that support community health innovation. For example, the HDRMHS has worked with minority communities, including tribal populations, to raise awareness of Michigan's Medicaid expansion and encourage the use of preventive health services. It has also partnered with community health centers on literacy programs that focus on health and health insurance.

Strengthening community engagement, capacity, and empowerment is the HDRMHS's fifth strategy. It builds partnerships by creating linkages between governmental and nongovernmental organizations with shared goals.

### Partnerships

| | |
|---|---|
| Primary collaborators | • MDHHS Bureau of Epidemiology and Population Health<br>• Mercy Health (part of Trinity Health)<br>• Michigan Department of Civil Rights<br>• Michigan Public Health Institute<br>• Practices to Reduce Infant Mortality through Equity Initiative |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

The HDRMHS collaborates with a wide range of organizations to reduce health disparities and improve minority health. For example, for the Practices to Reduce Infant Mortality through Equity (PRIME) Initiative, it partners with several organizations (i.e., the MDHHS, the Michigan Public Health Institute, the W.K. Kellogg Foundation, academic institutions, public health entities, and advocacy groups) on many activities, including cultural competency and health equity trainings. The Michigan Public Health Institute also works closely with the HDRMHS on other activities—such as social justice trainings and a collective impact assessment of MDHHS activities—and has a contract with the MDHHS formalizing the partnership. The institute also contracts with the HDRMHS on independent health equity efforts. Additional HDRMHS partners on health equity activities include other state agencies and MDHHS bureaus, as well as community health centers.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $884,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $484,000 |
| Largest funding source | State government |
| Anticipated changes to budget | None reported |

The total FY 2015 funding for the HDRMHS was $884,000. The HDRMHS received $484,000 in state funding, including $283,000 from State General Funds and $201,000 from the Healthy Michigan Fund. It also received a $400,000 Federal Preventive Health and Health Services Block Grant in FY 2015.

The HDRMHS issued National Minority Health Month mini-grants to community-based organizations, faith-based organizations, community health centers, educational institutions, youth-serving agencies, and local health departments. It also provided funding for cultural competency trainings, implementation of the National CLAS Standards among partner organizations, and health literacy programs aimed at increasing the use of preventive health services. The HDRMHS also assists in funding the MDHHS's standalone Minority Health BRFSS surveys.

# Michigan

## Michigan State Data

| Total Population[a]: 9,928,300 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 5.0 | 95.1 | 78.5 | 13.8 | 0.5 | 3.0 | 4.3 | 100.0 | NA |
| Percent of population medically uninsured[a] | 12.5 | 5.2 | 5.0 | 7.5 | 10.5 | 7.1 | 8.0 | 5.6 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 9.0 | 6.4 | 5.1 | 12.4 | SP | SP | NC | 6.5 | 5.9 |
| Age-adjusted mortality rate[b] | 634.2 | 786.1 | 765.9 | 971.2 | 825.9 | 327.7 | NC | 785.4 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 12.2 | 16.5 | 15.7 | 20.8 | 20.1 | 6.8 | 19.7 | 16.3 | 13.6 |
| Percent with diabetes[c] | 9.7 | 11.3 | 10.9 | 12.6 | 12.4 | 9.2 | 13.9 | 11.2 | 10.8 |
| Percent with heart disease[c] | 2.5 | 5.3 | 5.5 | 3.9 | 9.7 | 0.8 | 5.0 | 5.1 | 4.3 |
| HIV rate[d] | 230.6 | NC | 75.3 | 736.4 | 55.3 | 45.0** | 378.2 | 174.6 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 63.6 | 74.3 | 73.1 | 80.5 | 69.2 | 69.8 | 67.6 | 73.9 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 67.6 | 70.7 | 72.0 | 63.9 | 61.5 | 71.8 | 57.4 | 70.5 | 66.5 |
| Percent received flu vaccine[c] | 33.6 | 36.6 | 38.4 | 27.0 | 30.9 | 32.5 | 31.0 | 36.5 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

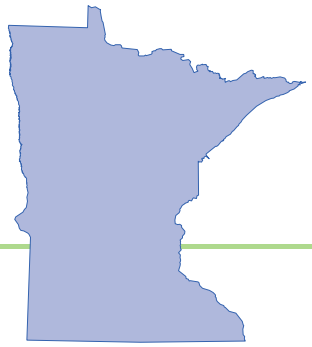
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 45.0 per 100,000 population (109 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 94.1 per 100,000 population (2 cases).

# Minnesota



## Introduction to Minnesota's Health Equity Activities

Minnesota had an estimated 2016 population of 5,520,000. Blacks/African Americans are the largest racial-ethnic minority population (6 percent), followed by Hispanics/Latinos (5 percent), Asian Americans and NHOPI (5 percent), and American Indians/Alaska Natives (1 percent). Persons self-identifying as multiracial or "other race" comprise 5 percent of the population.[1] Approximately 464,000 Minnesota residents live within a primary care health professional shortage area.[2]

In 1993, the state established an Office of Minority Health, which was renamed the Office of Minority and Multicultural Health (OMMH) in 2001. The office's first strategic plan, which sought to increase awareness of racial and ethnic disparities, was published in 1995. Its 1997 "Populations of Color in Minnesota – A Health Status Report" helped lay the foundation for its 1998 legislative report calling for the collection of standardized racial and ethnic health data. Today, the Executive Office of the Minnesota Department of Health includes the Centers for Health Equity and Community Health (CHECH), which is comprised of four centers: the Center for Health Equity (CHE), the Center for Health Data, the Center for Emergency Preparedness and Response, and the Center for Public Health Practice. The OMMH is housed within the CHE. Established in 2013 after a statewide assessment documented a range of health inequities, the CHE was developed to advance health equity by engaging communities and incorporating advancement of health equity in all of the MDH's activities.[3] The CHE regularly interacts with the Center for Health Data and its Center for Health Statistics on health equity projects involving disparities research.

Until 2016, the OMMH included an advisory committee. In early 2017, the MDH created an agency-wide Health Equity Advisory and Leadership (HEAL) Council. The new external group represents communities most impacted by health inequities and meets regularly to advise the MDH on a range of health equity issues.

### Minnesota Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Center for Health Equity (which includes the Office of Minority and Multicultural Health) |
| Strategic plan in place to address minority health or health equity | Minnesota Department of Health Strategic Plan |
| Date strategic plan was last updated | 2017 |
| Assessment plan in place to measure progress toward reducing health disparities | Yearly work plans assess progress toward goals of the strategic plan. An employee survey includes items on health equity activities. |
| Key strategies used to achieve health equity | • Build a shared understanding and internal capacity for advancing health equity.<br>• Identify and creatively address barriers to working differently.<br>• Change systems, structures, and policies that perpetuate inequities and structural racism.<br>• Listen authentically to and partner with communities.<br>• Improve the collection, analysis, and use of data for advancing health equity.<br>• Communicate our commitment to advancing health equity |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 Minnesota Department of Health. About the Center for Health Equity. Available on the Center for Health Equity website. Last accessed 7/17/17.

## Organizational Structure

The CHE was established in 2013 in tandem with a health equity report that revealed significant health disparities in Minnesota. The CHE has nine full-time staff members. Staff include a director, assistant director, a community engagement planner, a health equity planner/coach, two grant managers, one research scientist, one management analyst, and one administrative assistant. Additional staff across the MDH also spend time on health equity issues. The CHE works closely with the director of its parent division, the CHECH, as well as its assistant director and staff in the Center for Public Health Practice and the Center for Health Statistics. An MDH tribal director leads efforts on health equity in American Indian populations in Minnesota.

The CHE regularly hosts summer interns for either academic credit or salary. Community partners frequently volunteer to help at CHE community events or through advisory committees. No upcoming staffing changes are anticipated.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Center for Health Equity is one of four centers within the Centers for Health Equity and Community Health in the Minnesota Department of Health. |
| SMHE staffing (full-time equivalents) | 9 |
| Advisory committee or panel | MDH external health equity (HEAL) council<br>MDH I-HEALTH (internal health equity) council |

## Program Goals and Activities

The MDH's agency-wide strategic plan for 2015–2019 asserted that "to achieve a state where everyone in Minnesota has the opportunity to be healthy, regardless of race, ethnicity, gender, social class, or geography, MDH must become better equipped to advance health equity."[4] The plan focuses on health equity across six identified strategic areas: building internal capacity and a shared understanding of what creates health, community engagement, data collection and analysis, policy systems and structures, identifying barriers, and communicating the MDH's commitment to advancing health equity.

The agency-wide strategic plan, publically available on the MDH website, was created with input from the CHE with the intent to influence work across the MDH in order to close the gaps in health disparities. The most recent MDH strategic plan applies to FY 2015–2019. The OMMH created previous health equity-related plans.

The MDH strategic plan serves as a roadmap for developing specific work plans across the agency. The CHE and the Center for Public Health Practice are working together to develop a work plan that assesses progress toward the goals laid out in the agency's strategic plan. The work plan focuses on how the agency is doing work differently to better address health disparities. The MDH also administers an employee survey every 2 years to assess progress across the department. The survey addresses comfort level in talking about race and feeling equipped to conduct work to advance health equity.

Minority health, health disparities, and health equity priorities in Minnesota are set largely from the multi-year recommendations from the legislatively mandated 2014 Advancing Health Equity in Minnesota report that provides an overview of health disparities in Minnesota. The report emphasized the social determinants of health, stressed a health in all policies approach, and made seven recommendations:

1. Advance health equity through a health in all policies approach.
2. Continue investments in efforts that are currently working to advance health equity.
3. Provide statewide leadership for advancing health equity.
4. Strengthen community relationships and partnerships to address health equity.
5. Redesign MDH grant making to advance health equity.
6. Make health equity an emphasis throughout the agency.
7. Strengthen the collection and analysis of data to advance health equity.

4 Minnesota Department of Health. MDH Strategic Plan Annual Report (2016) and Work Plan (2017). Available on the MDH website. Last accessed 7/17/17.

# Minnesota

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Center for Health Equity | CHE |
| Center for Health Equity and Community Health | CHECH |
| Minnesota Department of Health | MDH |
| Office of Minority and Multicultural Health | OMMH |

The CHE has ongoing conversations to engage with the ethnic, community-based, and faith-based organizations and other partners that contributed to the report. It prioritizes building trust and maintaining transparency throughout processes to advance health equity.

The Centers for Health Equity and Community Health division collaborates to develop and promote trainings on health equity for staff and executive leadership across the MDH. In December 2016, the centers began offering 4-hour training sessions on racial equity to MDH staff, and continue to provide educational programming on an ongoing basis for staff across the department. To date, one-third of the 1,500 MDH staff have been trained. Many MDH staff also have attended the governmental Minnesota Tribal and State Relations Training. Finally, the MDH initiative, "Changing the Narrative About What Creates Health—Essential Steps in Improving Population Health in Minnesota," further builds staff capacity to advance health equity. These trainings all focus on reframing the dominant narrative that health is simply about health care or an individual's behaviors. Currently, the CHECH also offers additional trainings, such as a community engagement training and and narrative training, to promote a deeper understanding of health equity issues and how to change the narrative around what creates health.

In addition to building organizational capacity to advance health equity within the MDH, the CHE and the Center for Public Health Practice (PHP) work together to build community capacity to advance health equity. For example, the CHE grant managers provide training, technical assistance, and consultation to over 30 Eliminating Health Disparities Initiative grantees. Others within CHECH provide training and technical assistance to local public health partners collecting and analyzing health equity data; staff within the PHP and the Center for Health Statistics worked closely with public health departments to implement a health equity data guide. The CHECH recently piloted a new health equity data assessment with 10 local community health boards and plans to support the additional remaining 31 community health boards in local public health to conduct data assessment.

The CHECH also works with local public health (LPH) departments and community-based organizations to enhance community engagement through conversations on advancing health equity. Staff regularly conduct presentations with LPH community leadership teams and others to share insights about disparity-reduction strategies and learn about local activities. Since November 2016, the CHE has hosted three community conversations averaging ~150–300 attendees per event from community-based, social services, and local public health organizations. The community conversations focused on challenges and lessons learned from previous health equity efforts. More information about these events is available on the CHE website.

As part of its strategy to advance health equity, the CHE oversees several grants, many of which are legislatively mandated through the Eliminating Health Disparities Initiative grant program. Established in 2001, this program was designed to help reduce health status gaps among populations of color, including American Indians. Grantees include 32 community-based organizations, clinics, and tribes and focus on priority health areas, including breast and cervical cancer screening, diabetes, cardiovascular disease, diabetes, HIV/AIDS and STIs, immunizations, infant mortality, teen pregnancy, and violence and unintentional injury.[5]

The CHE also administers advancing health equity grant programs to organizations addressing health disparities through policy and systems change. The CHE administers a grant to Voices for Racial Justice, a project focusing on incarceration among populations of color and its impact on the health of those incarcerated, their families, and their communities. The CHE also oversees a grant to Neighborhood Hub, which focuses on social determinants of health and how housing impacts health in the North Minneapolis community.

In addition, as a part of the MDH's effort to view health through a "health equity lens" in all MDH grant programs, the CHE is working to ensure that health equity is a criterion for state-funded project awards. For example, the Statewide Health Improvement Part-

5 Minnesota Department of Health. Priority Health Areas of the Eliminating Health Disparities Initiative. Available on the MDH website. Last accessed 7/17/17.

nership, which funds local public health partners and community organizations throughout the state, includes a significant health equity component. That program focuses on reducing obesity, promoting healthy physical activity and eating, and reducing tobacco use, and requires each grantee to have a community leadership team that provides data on health equity.

Finally, throughout its activities, the MDH advocates a "Health-in-all-Policies" philosophy. As former president of the Association of State and Territorial Health Officials, former MDH Commissioner Ehlinger made nearly 100 health equity-related presentations in 2016 and challenged other state health commissioners across the country to adapt a health equity plan as part of their work. The MDH Commissioner regularly meets with the Minnesota governor's cabinet and engages in conversations across many agencies and sectors, such as transportation and housing.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Local city and county public health departments<br>• 32 Eliminating Health Disparities Initiative Grantees (community-based organizations, clinics, and tribes)<br>• 2 advancing health equity grantees: Voices for Racial Justice and Neighborhood Hub (ended in 2017)<br>• Statewide Health Improvement Partnership grantees<br>• Other community-based organizations |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

Several organizations collaborate with the CHE to work toward eliminating health disparities and advancing statewide health equity. For example, as noted above, many local health departments have formal partnerships with the CHECH through the Statewide Health Improvement Partnership grant program to reduce obesity and tobacco use. The CHECH also partners with local public health departments on strategies to collect and use health equity data.

Through a 5-year State Partnership Initiative to Address Health Disparities (SPI) grant from the U.S. Office of Minority Health, the CHE works with local health professionals and community leaders in Hennepin County on reducing infant mortality in the African American population. The CHE also formally partners with its 32 Eliminating Health Disparities Initiative grantees (i.e., community-based organizations, clinics, and tribes) and 2 advancing health equity grantees (Voices for Racial Justice and Neighborhood Hub) on trainings, technical assistance, and consultation on health equity activities. In addition, the CHE regularly works with a variety of community partners informally.

The MDH and the CHE coordinate on health equity initiatives with other state government agencies including the Department of Transportation, the Department of Housing and Urban Development, and the Department of Human Services. In 2016, the CHE was legislatively mandated to collaborate with the Department of Human Services, the Department of Public Safety, and the Council on Asian Pacific Minnesotans to conduct a working group report on violence against Asian women and children. The report is available on the CHE website.

## Funding

| | |
|---|---|
| Annual budget (FY 2016) of state/territorial minority health entity (SMHE) across all income sources | Over $6 million |
| Annual budget (FY 2016) of SMHE from state/territorial government | Over $6 million |
| Largest funding source | State funding for the Eliminating Health Disparities Initiative |
| Anticipated changes to budget | Possible budget reductions |

The total FY 2016 funding for the CHE was more than $6 million. Significant state funding sources for health equity activities include funding for the Eliminating Health Disparities Initiative (over $5 million), funding for the Advancing Health Equity Grants ($500,000), and funding for the Working Group on Violence Against Asian Women and Children ($200,000). Federal sources for health equity include an annual U.S. Office of Minority Health grant ($195,000/year) and portions of Minnesota's Preventive Health and Health Services Block Grant from the Centers for Disease Control and Prevention.

The CHECH has provided funding to local public health departments, clinics, and other community-based organizations through its several grantee programs. Possible reductions in funding for the CHE are anticipated.

# Minnesota

## Minnesota State Data

| Total Population[a]: 9,928,300 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 5.1 | 94.9 | 83.2 | 5.9 | 1.1 | 4.9 | 4.9 | 100.0 | NA |
| Percent of population medically uninsured[a] | 18.5 | 3.6 | 3.4 | 7.5 | 19.2 | 3.7 | 14.6 | 4.4 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 5.2 | 4.2 | 10.4 | SP | 6.0 | NC | 5.2 | 5.9 |
| Age-adjusted mortality rate[b] | 387.8 | 650.6 | 641.4 | 713.0 | 1073.2 | 446.4 | NC | 648.1 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 8.0 | 11.3 | 11.0 | 15.1 | 22.6 | 7.7 | 11.8 | 11.2 | 13.6 |
| Percent with diabetes[c] | 8.1 | 8.4 | 8.4 | 9.1 | 17.9 | 5.7 | 10.9 | 8.5 | 10.8 |
| Percent with heart disease[c] | 1.5 | 3.6 | 3.9 | 1.6 | 2.7 | 1.3 | 2.5 | 3.6 | 4.3 |
| HIV rate[d] | 392.4 | NC | 100.3 | 736.4 | 232.0 | 69.1** | 362.3 | 171.3 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 67.2 | 71.4 | 71.5 | 76.3 | 68.9 | 62.7 | 69.1 | 71.3 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 59.9 | 75.2 | 76.1 | 62.2 | 62.1 | 73.8 | 60.4 | 74.7 | 66.5 |
| Percent received flu vaccine[c] | 37.6 | 44.4 | 44.9 | 39.3 | 40.1 | 41.7 | 35.8 | 44.2 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

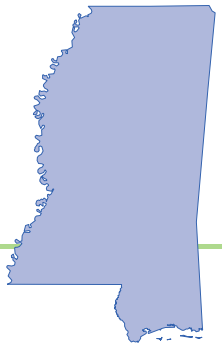
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 69.1 per 100,000 population (141 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 255.2 per 100,000 population (5 cases).

# Mississippi



**Special Note:** The information in this profile is from FY 2015 and does not reflect the Mississippi State Department of Health's (MSDH) current organizational structure or health equity strategies. Like many states, the MSDH has faced challenging budget cuts in the last few years. During FY 2016, the MSDH received a 30 percent budget cut in state general funds, thereby forcing an organizational restructure for the MSDH, particularly in programs heavily funded with state dollars. As a result, the Office of Health Disparity Elimination was merged with the Office of Policy Evaluation and Government Relations. On a positive note, this transition encouraged the focus of health equity as a cross cutting strategic priority to be engrained in all of the organization's policies, processes, and procedures. It fosters strategies to assure health equity in all of the programs and to promote Health in all Policies throughout the agency and with its partners and collaborators. The MSDH kept the positions of the Health Equity Director, Operations Management Analyst, and a part-time bilingual coordinator.

## Introduction to Mississippi's Health Equity Activities

Mississippi had an estimated 2016 population of 2,989,000. Blacks/African Americans are the largest minority population (38 percent), followed by Hispanics/Latinos (3 percent), Asian Americans and NHOPI (1 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 2 percent of the population.[1] Approximately 1,748,000 Mississippi residents live within a primary care health professional shortage area.[2]

In 2003, the MSDH's Office of Health Promotion and Health Equity (OHPHE) created the Office of Health Disparity Elimination (OHDE) specifically to address health disparities. Its mission is "to identify health inequities and their root causes and to promote evidence-based solutions to create a more equitable system" (MSDH/OHDE, 2015). A 2015 report prepared by the MSDH/OHDE and Office of Health Data and Research, *State of the State: Annual Mississippi Health Disparities and Inequalities Report*,[3] examines health disparities throughout Mississippi. The first report of its kind, it highlights inequalities in health among Mississippi's racial and ethnic minority populations.

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 *State of the State: Annual Mississippi Health Disparities and Inequalities Report*. Available on the MSDH website.

# Mississippi

### Mississippi Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Mississippi State Department of Health, Office of Health Disparity Elimination |
| Strategic plan in place to address minority health or health equity | A strategic plan with a specific focus on minority health or health equity is not available. The comprehensive Mississippi State Department of Health Strategic Plan[4] includes strategies for addressing health disparities in minority populations as part of its larger goals of improving health for all Mississippians. A State Health Improvement Plan is being developed and will include approaches for reducing health disparities. |
| Date strategic plan was last updated | The Mississippi State Department of Health Strategic Plan was last updated in November 2014. |
| Assessment plan in place to measure progress toward reducing health disparities | The Mississippi State Department of Health Strategic Plan includes measureable objectives for each fiscal year. In conjunction with the forthcoming State Health Improvement Plan, the MSDH plans to develop processes for evaluating outcomes and measuring progress toward Statewide health goals. |
| Key strategies used to achieve health equity | • *Bridging the Gap*: Medical interpreter trainings<br>• Assessment of National Standards for Culturally and Linguistically Appropriate Services (National CLAS Standards)<br>• Community Research Fellows Training<br>• Tobacco cessation efforts in vulnerable populations<br>• Hypertension education in barbershops<br>• *Sisters United* infant mortality reduction project |

## Organizational Structure

The MSDH/OHDE was established in 2003 to address health disparities and minority health issues in the State. Advisory committees are sometimes formed for specific activities or initiatives that the office leads; however, there is no ongoing presence of a committee or panel that advises on minority health or health disparity issues. Located within the MSDH's Office of Health Promotion and Health Equity (OHPHE), the OHDE works collaboratively with the Office of Tobacco Control and the Office of Preventive Health to promote health and health equity for all Mississippi residents.

The MSDH/OHDE has eight full-time staff members who dedicate their time to minority health and health disparity initiatives. Full-time staff include the office's director, the director of its Cultural and Linguistic Services Division, the director of Data and Targeted Programs, two health program specialists, the director of Health Promotion and Education, a special project officer, an administrative staff member, an operations manager analyst, and an operation manager. The OHPHE Director dedicates time equally between the Office of Tobacco Control, the OHDE, and the Office of Preventive Health—and therefore spends one third time working exclusively on minority health initiatives. MSDH/OHDE occasionally engage unpaid interns to help with its activities.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/ territorial government | The OHDE is housed within the Mississippi State Department of Health, Office of Health Promotion and Health Equity. |
| SMHE staffing (full-time equivalents) | 8 |
| Advisory committee or panel | None |

4 Mississippi State Department of Health Fiscal Years 2016-2020: Strategic Plan. Prepared in Accordance with the Building a Better Mississippi Instructions, November 2014. Available on the MSDH website.

## Program Goals and Activities

The MSDH has an overarching Health Strategic Plan—last updated in November 2014—that addresses minority health and health disparities as part of its larger goal to improve the health of all Mississippians. However, neither the MSDH nor its subdivisions have developed a strategic plan focusing specifically on minority health and healthy equity. The Office of Preventive Health and the Office of Tobacco Control has developed project-specific strategic plans to address priority health concerns in the State, such as tobacco control and stroke prevention—and these plans address health equity as part of their overall objectives. These individual plans, developed for a 5-year time span, are publicly available.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Mississippi State Department of Health | MSDH |
| Office of Health Disparity Elimination | OHDE |
| Office of Health Promotion and Health Equity | OHPHE |

To provide a broader, up-to-date vision, the MSDH is developing a State Health Improvement Plan, with input from many nongovernmental stakeholders, which will focus on reducing health disparities. In conjunction with the State Health Improvement Plan development, the MSDH plans to implement a system to evaluate outcomes and measure progress toward the plan's goals and objectives. Future updates to the MSDH Strategic Plan will address specific Plan-identified health priorities.

The MSDH/OHDE is working on many strategies to achieve health equity and eliminate disparities among Mississippi's racial and ethnic minority populations. In recent years, the office has made substantial progress in identifying priority areas related to health equity, aided by the NIH Health Disparities Strategic Plan and Budget,[5] the National Prevention Strategy,[6] and the Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities.[7] The MSDH/OHDE has procured grants that help with priority setting. Community advisory boards at times offer advice on priorities and activities within specific communities. In addition, the MSDH/OHDE has been working with the U.S. Office of Minority Health to learn about national priorities related to health disparities and identify what the office can address at the State level.

One major MSDH/OHDE strategy is to offer medical interpreter trainings to staff at health departments, federally qualified health centers, community health centers, and hospitals. The MSDH/OHDE became licensed in medical interpretation through the "Bridging the Gap Cross Cultural Health Care Program," enabling it to provide 40-hour trainings. Previously, no trainings were available for medical interpreters in the state. In addition, the MSDH/OHDE offers workshops for health care providers on how to work effectively with interpreters.

In 2014, the MSDH/OHDE initiated an effort to educate all MSDH employees and staff at Mississippi's nine public health districts on the National Standards for Culturally and Linguistically Appropriate Services (National CLAS Standards), as well as on other aspects of cultural and linguistic competence. The MSDH partnered with Georgetown University to develop these trainings. Subsequently, the MSDH/OHDE worked with Georgetown University to survey MSDH staff, interview key informants, and conduct patient focus groups to assess the use of the National CLAS Standards within the MSDH. This assessment also included a policy scan of MSDH manuals to identify reference to and use of CLAS Standards. Its results, which the MSDH/OHDE presented to department leadership, identified short-term actions, including providing more National CLAS Standards trainings for department employees and implementing more signage about language services offered in MSDH settings. The MSDH/OHDE also plans to share the assessment results with the public health districts and will continue reviewing departmental policy language to assess the need for any new policies regarding the National CLAS Standards.

The MSDH/OHDE also leads Mississippi's *Sisters United*—an infant mortality education program funded through a grant from the March of Dimes—in collaboration with the Maternal and Child Health division of the Office of Health Services. Under a memorandum of understanding with graduate sorority chapters in the State, *Sisters United* partners with African American sorority chapters and engages graduate members

5 U.S. Department of Health and Human Services, NIH Health Disparities Strategic Plan and Budget: Fiscal Years 2009-2013. Available on the NIMHD NIH website.

6 U.S. Department of Health and Human Services National Prevention Strategy. Available on the Surgeon General's website.

7 U.S. Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities. Available on the U.S. Office of Minority Health's website.

in train-the-trainer sessions. A training video aimed at sorority chapters, developed by the MSDH/OHDE, features four evidence-based strategies to prevent infant mortality: folic acid intake, breastfeeding, safe sleep practices, and healthy weight management. After the training, the sororities take the information back to their communities and conduct infant mortality prevention education events. *Sisters United* was initiated in three public health districts in Mississippi with high infant mortality rates, and then has been expanded to other districts.

Another MSDH/OHDE effort aimed at reducing health disparities is the Community Research Fellows Training. This 16-week research training program seeks to empower minority and other underserved populations and improve community knowledge and capacity to participate in research. The training covers many aspects of research, including quantitative data collection, qualitative data collection, and clinical trials. Program participants learn how to be better consumers of research and encouraged to use this knowledge to identify and address issues in their community.

Tobacco cessation is a specific topic around which Mississippi seeks to reduce health disparities. The Office of Tobacco Control leads these efforts, as outlined in its strategic plan. Relatedly, the MSDH/OHDE partners with the Institute for Disability Study on activities related to tobacco cessation in vulnerable populations, including the Leadership Academy, a statewide initiative to reduce tobacco usage. Many stakeholders, including state agencies, health plans, and substance abuse/mental health organizations participate in the Leadership Academy. The Office of Tobacco Control has worked with the U.S. Substance Abuse and Mental Health Services Administration (a partner in the Leadership Academy) to develop and implement tobacco cessation strategies. A website that is being developed for health care providers and community members will provide resources for tobacco cessation.

The Mississippi Office of Preventive Health has a collaborative agreement with the U.S. Centers for Disease Control and Prevention to address cardiovascular disease in the Mississippi Delta, a region with a high proportion of African Americans and people of low socioeconomic status. One part of the agreement aims to educate African American men about cardiovascular disease. Ongoing activities include screenings in barbershops, referrals to services, and education about hypertension. The Office of Preventive Health has developed toolkits to expand the program beyond the Delta area.

### Partnerships

| | |
|---|---|
| Primary collaborators | • My Brother's Keeper<br>• Boat People SOS<br>• Mercy Housing and Human Development<br>• Gulf States Health Policy Center<br>• Public and private educational institutions<br>• Local health departments<br>• Mississippi State Department of Health: Office of Tobacco Control, Office of Preventive Health, and Office of Adolescent Health<br>• i-Think Group |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships |

In addition to the work described above, the MSDH/OHDE partners with many governmental and nongovernmental organizations to work towards eliminating health disparities and advancing health equity in the state. For example, the MSDH/OHDE collaborates with community-based organizations to provide education on the Affordable Care Act and disseminate information in particular minority communities. One such organization, My Brother's Keeper, seeks to reduce health disparities by improving the health and well-being of minority populations. The MSDH/OHDE works with My Brother's Keeper on several contracts, including the Community Research Fellows Training program and efforts to educate Mississippi's minority communities about the Affordable Care Act.

Another major partner, Boat People SOS, connects the MSDH/OHDE with the Vietnamese community. Boat People SOS is a community-based organization that focuses on empowering and improving the health of Vietnamese populations. MSDH/OHDE has formal contracts with Boat People SOS to provide Vietnamese translation services and to conduct collaborative work around, for example, hepatitis B, as well as general Affordable Care Act education efforts within Vietnamese communities. The MSDH/OHDE also has a formal contract with Mercy Housing and Human Development for hepatitis B activities in Vietnamese communities and other vulnerable populations.

The MSDH/OHDE has a partnership with Gulf States Health Policy Center to offer the Community Research Fellows Training Program in 2016.

Additionally, the MDHE/OHDE partners with several academic institutions to improve health equity in the state. The Healthy Linkages Initiative—a collaboration between the MHDE/OHDE, the University of Mississippi Medical Center, and federally qualified health centers—was established after Hurricane Katrina to improve communication between the partnering organizations and improve access to health care for minority and vulnerable populations. Tougaloo College, a historically black college located in Tougaloo, is another major partner that works with the office to provide Affordable Care Act education. MHDE/OHDE also partners with the University of Southern Mississippi and the University of Mississippi Center for Population Study. A professor at the University of Southern Mississippi supports research and analysis on minority health issues for the office, and the University of Mississippi Center for Population Study assists with qualitative research initiatives and has provided support for the Community Research Fellows Training program.

In addition to the nongovernmental and academic collaborators, MSDH/OHDE partners with local health departments, the nine public health districts, and other MSDH agencies. For example, the MSDH/OHDE works closely with local health departments to disseminate information and carry out activities within local communities. It also partners with other MSDH programs—including the Office of Tobacco Control, Office of Preventive Health, and Office of Adolescent Health—on activities to eliminate health disparities and advance health equity for minority and other vulnerable populations.

To conduct community education about the Affordable Care Act, the MSDH/OHDE has hired the i-Think Group, a policy-oriented consultant organization. The i-Think Group also participated in a partnership with the office, the University of Mississippi Medical Center, and federally qualified health centers to conduct Affordable Care Act education throughout the state.

## Funding

| | |
|---|---|
| Annualized budget (FY 2015) of State/territorial minority health entity (SMHE) across all income sources | $750,000–798,000 |
| Annual budget (FY 2015) of SMHE from State/territorial government | $500,000 |
| Largest funding source | State government |
| Anticipated changes to budget in FY 2016 | Possible |

The total FY 2015 funding for the MSDH/OHDE was $750,000–798,000. In FY 2015, the office had four key funding sources: One was the State of Mississippi ($500,000), an amount that has been consistent over the past 3 years. The MSDH/OHDE received a grant of $150,000–$198,000 from the U.S. Office of Minority Health to prevent hepatitis B in Vietnamese communities. It also received a $25,000 grant from the March of Dimes Foundation and a $75,000 grant from the State Infant Mortality Program to address the state's high infant mortality by funding the Mississippi *Sisters United* project. The office may not receive the same level of funding for infant mortality reduction in FY 2016, but no significant changes in funding levels from the State of Mississippi or the U.S. Office of Minority Health are anticipated.

The MSDH/OHDE provides funding to some nongovernmental community organizations to advance health equity. For example and as noted above, African American sorority chapters at universities in the state that are involved in Mississippi *Sisters United* receive small grants to address infant mortality in minority communities. The MSDH/OHDE also provides funding to Boat People SOS and Mercy Housing and Human Development to carry out hepatitis B prevention activities in Vietnamese communities (the funding was awarded by the U.S. Office of Minority Health). Finally, Tougaloo College also receives MSDH/OHDE funding through a subgrant provided by the University Of Mississippi Medical Center to educate and link the public to Affordable Care Act resources.

# Mississippi

## Mississippi State Data

| Total Population[a]: 2,988,726 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 2.9 | 97.1 | 58.5 | 38.0 | 0.4 | 0.9 | 2.2 | 100.0 | NA |
| Percent of population medically uninsured[a] | 30.5 | 12.0 | 10.6 | 14.8 | 24.6 | 10.6 | 25.3 | 12.6 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 9.7 | 7.0 | 12.5 | SP | SP | NC | 9.5 | 5.9 |
| Age-adjusted mortality rate[b] | 215.7 | 959.1 | 918.3 | 1012.0 | 706.5 | 469.0 | NC | 948.9 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 8.7 | 12.8 | 12.3 | 13.2 | 13.8 | SP | 18.0 | 12.7 | 13.6 |
| Percent with diabetes[c] | 7.2 | 13.7 | 12.1 | 16.9 | 8.8 | SP | 9.7 | 13.7 | 10.8 |
| Percent with heart disease[c] | 0.0 | 6.0 | 7.0 | 4.2 | 5.1 | SP | 5.3 | 5.9 | 4.3 |
| HIV rate[d] | 451.7 | NC | 122.5 | 750.8 | 96.3 | 66.3** | 1985.8 | 374.0 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 55.1 | 75.9 | 72.5 | 81.4 | 82.3 | SP | 56.6 | 75.3 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 62.8 | 57.3 | 59.5 | 53.2 | 57.9 | SP | 60.7 | 57.4 | 66.5 |
| Percent received flu vaccine[c] | 42.0 | 37.0 | 41.5 | 30.2 | 26.5 | SP | 25.6 | 37.2 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

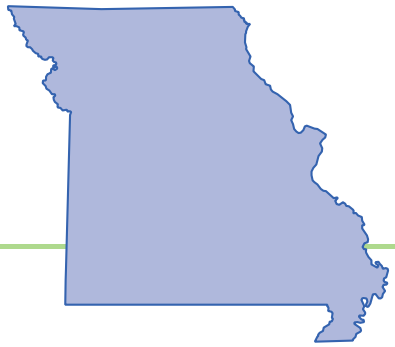
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 66.3 per 100,000 population (17 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 114.9 per 100,000 population (1 case).

# Missouri



## Introduction to Missouri's Health Equity Activities

Missouri had an estimated 2016 population of 6,093,000. Blacks/African Americans are the largest racial-ethnic minority population (12 percent), followed by Hispanics/Latinos (4 percent), Asian Americans and NHOPI (2 percent), and American Indians/Alaska Natives (less than 1 percent). Multiracial and persons self-identifying as "other race" comprise 4 percent of the population.[1] Approximately 2,314,000 Missouri residents live within a primary care health professional shortage area.[2]

Housed within the Missouri Department of Health and Senior Services (DHSS), the Missouri Office of Minority Health (MOMH) was established solely to address minority health, health disparities, and health equity. It was formed largely as a result of efforts by the Missouri Legislative Black Caucus (LBC). In partnership with the MOMH, a volunteer regional health alliance with representatives from each of the state's six MOMH districts (Eastern, Northwestern, Northwestern, Central, Southeastern, and Southwestern) provides insight on health equity issues in Missouri. It holds regular calls to discuss current health equity issues and to hear from other organizations with which the MOMH seeks to build regional collaborations. This alliance is separate from the Regional Health Equity Council, which covers the four states in the U.S. Department of Health and Human Services' Region VII (Iowa, Kansas, Missouri, and Nebraska). The Regional Health Equity Council (RHEC) is comprised of directors of minority health and their designees in each of these four states. Various committees within the RHEC sponsor monthly conference calls to discuss pertinent issues affecting Region VII. With assistance from epidemiologists representing each state, the health equity council drafted a Health Equity Blueprint for Region VII.

### Missouri Minority Health Overview

| | |
|---|---|
| Name of state/territorial minority health entity | Missouri Office of Minority Health |
| Strategic plan in place to address minority health or health equity | A strategic plan is available at the department level. |
| Date strategic plan was last updated | 2016 |
| Assessment plan in place to measure progress toward reducing health disparities | No formal assessment plan is in place. |
| Key strategies used to achieve health equity | • Promotion of preventive screenings<br>• Promotion of exercise<br>• Promotion of heathy eating<br>• Promotion of regular visits to primary care physicians<br>• Promotion of heathy lifestyles |

## Organizational Structure

The MOMH is located within the DHSS Office of the Director and has a legislative mandate to advise the Director of DHSS on departmental, local, statewide, or federal policies and procedures that may adversely affect the health of minorities. Its four-person staff, including the MOMH chief, two health program representatives, and an administrative assistant, contribute all of their time to MOMH and DHSS activities. Interns and volunteers may also assist MOMH staff. There are no concrete plans to expand the number of employed staff.

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The MOMH is under the DHSS Office of the Director |
| SMHE staffing (full-time equivalents) | 4 |
| Advisory committee or panel | The regional health alliance |

## Program Goals and Activities

To address issues that may adversely impact minority health and to set priorities for its activities, the MOMH works closely with directors of other DHSS divisions (e.g., the Division of Senior and Disability Services, the Division of Regulation and Licensure, and the Division of Community and Public Health). The goals and activities of the MOMH strategic plan are integrated into the larger DHSS strategic plan. The DHSS strategic plan was a part of the 2016 Public Health Accreditation Board accreditation process, which eventually led to accreditation for the DHSS.

In addition to the DHSS strategic plan, the MOMH releases reports on a range of health equity issues (e.g., dental health disparities). These reports address topics of concern to racial and ethnic minorities; the lesbian, gay, bisexual, and transgender community; and rural health populations. Generated every 4 years by the MOMH—in partnership with the Office on Women's Health and the Office of Primary Care and Rural Health—the most recent set of reports were published in 2013–2014 and include strategies to improve health outcomes. The MOMH and DHSS measure progress toward reducing health disparities primarily by working with epidemiologists to review data and trends across known health disparity issues.

Most of the strategies underway to address minority health, health disparities, and health equity are related to health promotion and are led by the MOMH in conjunction with the Division of Community and Public Health. The MOMH uses tailored health messaging to engage individuals in minority communities and encourage them to participate. The initiatives supporting the preventive screenings strategies include Show Me Healthy Women, Sista Strut, and WISE-WOMAN—which offers screenings for breast cancer, cervical cancer, heart disease, and stroke prevention.

These initiatives accomplish goals similar to breast cancer walks, but with a significant focus on culturally competent marketing and outreach. Other related health promotion efforts include a prostate cancer walk, colorectal screenings, and dental screenings for children. These screening efforts mostly target African Americans and other minorities.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Missouri Office of Minority Health | MOMH |
| Missouri Department of Health and Senior Services | DHSS |
| Missouri Legislative Black Caucus | LBC |

The MOMH leads efforts to promote exercise and reduce obesity in an area of Kansas City with poor health outcomes. Efforts to promote healthy eating strategies include partnering with the American Heart Association to distribute healthy cookbooks and partnering with Hispanic and Asian leaders to address health food choices in grocery stores that serve specific racial and ethnic populations. The MOMH and the Division of Community and Public Health lead another related initiative, with assistance from the Office of Primary Care and Rural Health and the U.S. Department of Agriculture, which funds food trucks and/or community gardens that promote healthy eating. The MOMH has reviewed proposals to assess which might have the biggest impact on healthy eating in minority communities.

The MOMH and the Office of Primary Care and Rural Health lead the strategy to promote regular visits to primary care physicians. This involves working with federally qualified health centers to encourage community residents to get regular care and preventive screenings. Another strategy to promote healthy lifestyles includes faith-based initiatives and a smoking cessation quit line. In concert with one faith-based initiative, Fourth Sunday, the MOMH has partnered with pastors to encourage them to speak about health; in one case, a church was encouraged to operate a gymnasium.

# Missouri

### Partnerships

| | |
|---|---|
| Primary collaborators | • Missouri Legislative Black Caucus<br>• Black Health Care Coalition<br>• Lincoln University<br>• People's Health Centers<br>• I-Heart Radio |
| Contracts or memoranda of understanding with any partners | Yes, contracts are implemented for all partnerships except those with the Missouri Legislative Black Caucus and the Black Health Care Coalition. |

Most of the minority health strategies underway in Missouri involve partnerships with other organizations. The Missouri LBC is one of the most important MOMH partners, but no formal contract exists between the organizations. The MOMH informs the LBC about health outcomes of concern to African American communities, invites LBC members to attend forums held in their areas, and conducts educational sessions with LBC members. LBC members reach out to the MOMH to assist with health fairs (e.g., offering health screenings by a federally qualified health center at a community-wide event or initiating a campaign to distribute toothbrushes in rural areas). The MOMH also works with state legislators from underserved districts to address disparities due to socioeconomic status. The MOMH formally contracts with the Black Health Care Coalition in Kansas City for obesity prevention through the Fit Families initiative.

The MOMH also maintains a memorandum of understanding and a contract with Lincoln University, a historically black college/university (HBCU) that purchased technology enabling the MOMH to broadcast monthly educational webinars to senior citizens at all extension campuses. These webinars address topics such as heart health, Alzheimer's disease, and dementia. Lincoln University also hosts the Missouri Institute on Minority Aging forum, which presents current information affecting senior citizens. Initially, the forum solely served African American seniors, but it now serves a mix of African American and Hispanic seniors.

The MOMH supports the Betty Jean Kerr People's Health Centers, a federally qualified health center, and participates in a back-to-school festival where the MOMH facilitates the performance of health screenings to a very large minority population. The MOMH provided technical assistance to the Betty Jean Kerr People's Health Centers to build an adolescent mental health facility for children. In addition, the MOMH has an agreement with I-Heart Radio to support Sista Strut, a 5k walk to increase breast cancer awareness within the African American community.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $800,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $800,000 |
| Largest funding source | State of Missouri |
| Anticipated changes to budget | None |

The total FY 2015 funding for the MOMH was approximately $800,000. In FY 2015, the only source of funding was from the State of Missouri general revenue. Although the MOMH was involved in many of DHSS activities, the $800,000 was solely used to fund MOMH's activities and salaries. The MOMH activity budget supported Lincoln University and various other partnership programs. The amount of funding designated for the MOMH has decreased in past years.

# Missouri

## Missouri State Data

| Total Population[a]: 6,093,000 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 4.0 | 96.0 | 82.2 | 11.5 | 0.5 | 2.1 | 3.7 | 100.0 | NA |
| Percent of population medically uninsured[a] | 22.1 | 8.7 | 8.6 | 12.3 | 16.8 | 10.2 | 13.8 | 9.3 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 6.5 | 5.4 | 11.9 | SP | SP | NC | 6.5 | 5.9 |
| Age-adjusted mortality rate[b] | 384.0 | 815.6 | 794.5 | 975.8 | 297.0 | 400.1 | NC | 808.2 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 13.2 | 14.5 | 14.1 | 16.8 | 19.5 | 12.8 | 17.0 | 14.5 | 13.6 |
| Percent with diabetes[c] | 11.8 | 11.5 | 11.3 | 13.7 | 9.3 | 6.1 | 11.5 | 11.5 | 10.8 |
| Percent with heart disease[c] | 6.4 | 4.7 | 4.7 | 4.2 | 7.5 | 2.5 | 2.8 | 4.6 | 4.3 |
| HIV rate[d] | 361.9 | NC | 135.7 | 913.8 | 63.8 | 74.0** | 456.6 | 234.0 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 70.3 | 71.8 | 71.3 | 75.7 | 64.3 | 75.4 | 67.5 | 71.7 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 50.9 | 61.8 | 62.3 | 58.6 | 36.4 | 70.8 | 56.6 | 61.5 | 66.5 |
| Percent received flu vaccine[c] | 27.0 | 43.1 | 43.4 | 41.0 | 23.9 | 39.5 | 29.2 | 42.6 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

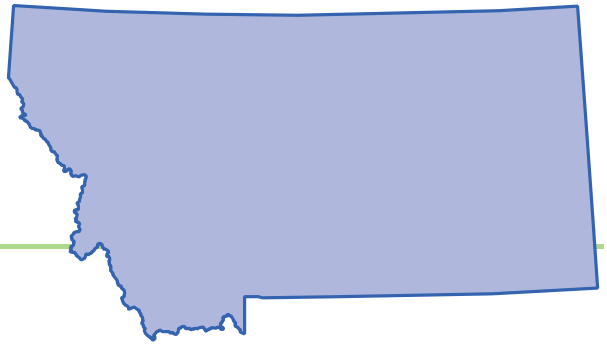
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 74.0 per 100,000 population (72 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 91.1 per 100,000 population (5 cases).

# Montana



## Introduction to Montana's Health Equity Activities

Montana had an estimated 2016 population of 1,043,000. American Indians/Alaska Natives are the largest racial-ethnic minority population (7 percent), followed by Hispanics/Latinos (4 percent), Asian Americans and NHOPI (1 percent), and Blacks/African Americans (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 3 percent of the population.[1] Approximately 330,000 Montana residents live within a primary care health professional shortage area.[2]

As one of only a few states in which American Indians/Alaska Natives comprise the largest racial-ethnic minority group, Montana established the Office of American Indian Health (OAIH) within the Department of Public Health and Human Services (DPHHS) per a 2015 governor-issued Executive Order. Its mission is to reduce disparities and improve a range of health outcomes (e.g., cardiovascular disease, cancer, and lifespan) for American Indians. Located within the department's Director's Office, the American Indian Health Director guides the department's effort to address minority health, health disparities, and health equity in Montana. Since 2013, a DPHHS tribal relations manager has been dedicated to improve the department's relationship with Montana's tribes, urban Indian programs, and Indian Health Service.

### Montana Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Montana/Office of American Indian Health |
| Strategic plan in place to address minority health or health equity | Not as of yet, but will be created once the American Indian Health Director position is filled in summer 2018. |
| Date strategic plan was last updated | N/A |
| Assessment plan in place to measure progress toward reducing health disparities | • The DPHHS's State of the State's Health: A State Health Assessment Report on the Health of Montanans (2013) identifies health disparity priorities.<br>• The DPHHS's State Health Improvement Plan (2012–2017) is a 5-year plan with annual updates addressing, among other topics, health disparities.<br>• Proposed priority areas for the DPHHS's 2018–2022 State Health Improvement Plan include disparities in chronic disease, maternal and child health, behavioral health, unintentional injury, and adverse childhood experiences. |
| Key strategies used to achieve health equity | • Conducting tobacco use reduction activities<br>• Conducting home visits with low-income pregnant women and new mothers<br>• Increasing access to the Women, Infants, and Children Program<br>• Increasing awareness about heart disease and stroke<br>• Ensuring availability of emergency preparedness plans |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

# Montana

## Organizational Structure

The American Indian Health Director (AIHD) is a staff position reporting directly to the DPHHS director who, in turn, reports to the governor. A tribal relations manager also works under the director, but is independent of the AIHD. The DPHHS consults with the AIHD and the tribal relations manager when working with tribes or seeking technical assistance. The AIHD position that vacated in early 2017. In addition, a mid-level tobacco prevention specialist in the Public Health and Safety Division works full-time with the tribes. Several mid-level staff in the Public Health and Safety Division also contribute to health disparity activities. Through the AmeriCorps VISTA program, others have worked on health disparity issues in the tobacco program. It is anticipated that staffing allocations may evolve over the next 2 years.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Office of American Indian Health operates directly under the director of the Department of Public Health and Human Services. |
| Advisory committee or panel | Chaired by the department director, the Internal Indian Health Collaborative was established in DPHHS in spring 2017 to focus on health disparities and developing strategies to address them in concert with the work of the AIHD. |

## Program Goals and Activities

The DPHHS Public Health and Safety Division, which oversees all public health programs, is guided by a 5-year strategic health plan. A public health assessment conducted every 5 years informs the strategic plan and helps to identifies priority public health issues.

While the strategic health plan addresses equity issues, its primary focus is to reduce disparities between rural and urban populations. The public health assessment, however, considers public health priorities of racial and ethnic minorities and specifically offers detailed information on racial-ethnic disparities affecting American Indians. A Public Health System Improvement Taskforce, which includes leaders of tribal and local health departments, develops the assessment, reviews its results, and subsequently suggests several key public health priorities. Additionally, the U.S. Indian Health Service funds the Rocky Mountain Tribal Epidemiology Center, which supports tribal public health workgroups and advisory coalitions that provide the OAIH feedback that it uses when establishing its priorities.

As part of state legislation regarding the use of state tobacco master settlement funds, the DPPHS must provide tobacco prevention services for Montana's recognized American Indian tribes of which there are eight, each with their own tribal governing body. Such services, which are coordinated through the DPHHS Public Health and Safety Division, include efforts to: reduce exposure to secondhand smoke, discourage smoking/electronic nicotine product use initiation among youth, implement smoke-free policies on school campuses and in low-income housing, and assist in tobacco cessation efforts. The DPHHS also offers tribes financial support to fund full-time tobacco use prevention staff. The Montana Tobacco Quit Line, operated through National Jewish Health in Denver, provides free or low-cost cessation materials to all Montanans. Most recently, DPHHS created the American Indian Commercial Tobacco Quit Line which seeks to make available American Indian counselors who can provide tailored services to tribal communities. To increase awareness of these services among Indian communities, the Public Health and Safety Division works with a media contractor to develop tribal-specific materials.

Through the Family and Community Health Bureau, the DPHHS supports evidence-based models for home visits with low-income pregnant women and new mothers—which are disproportionately Indian. The DPHHS works directly with participating tribes to help support low-income families with children under age 5, including home visits using the "Parents as Teachers" tribal-specific and culturally appropriate home visit model. Another Bureau program focuses on healthy nutrition by providing tribes with funding to implement the Women, Infants, and Children Program and supporting breastfeeding efforts. In a separate program, the DPHHS Nutrition and Physical Activity Program works with labor and delivery hospitals across Montana to support the Baby-Friendly Hospital Initiative, which certified a participating hospital on the Blackfeet Reservation.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Department of Public Health and Human Services | DPHHS |
| Office of American Indian Health | OAIH |

In addition, the Public Health and Safety Division has implemented a cardiovascular health awareness program to address heart disease morbidity and mortality disparities among American Indian communities, many of which are in remote locations with limited access to cardiology services. The program features tribal-specific campaigns about the warning signs and symptoms of heart attack and stroke. Plans are underway to expand telehealth capacity in small critical access hospitals, providing rapid access to neurologists. Another Public Health and Safety Division initiative, funded by the U.S. Centers for Disease Control and Prevention (CDC), seeks to ensure that each American Indian community has in place a DPHHS-reviewed emergency preparedness plan in the event of a flood, disease outbreak, or other natural disaster.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Tribal health department leaders<br>• Urban Indian Health Center leaders<br>• Billings Area Indian Health Service<br>• Montana Healthcare Foundation<br>• Rocky Mountain Tribal Epidemiology Center |
| Contracts or memoranda of understanding with any partners | Yes, contracts are implemented for some partnerships. For example:<br>• Multiple contracts are in place with tribal health leaders for various activities.<br>• DPHHS maintains a memorandum of understanding with the Rocky Mountain Tribal Epidemiology Center.<br>• DPHHS contracts with the Montana Healthcare Foundation in support of the projects it funds. |

Leaders from the health departments of Montana's federally recognized tribes are key DPHHS collaborators on efforts to improve American Indian health. The DPHHS maintains contracts with tribal health departments to support efforts around tobacco use prevention, healthy nutrition, and emergency preparedness; it also partners with other agencies to secure funding supporting additional American Indian health activities.

To help tribes conduct local community health assessments, the DPHHS maintains a memorandum of understanding to support data sharing with the Rocky Mountain Tribal Epidemiology Center, a nongovernmental agency funded by the U.S. Indian Health Service. The center has applied for additional funding on behalf of tribes for tribal specific projects (e.g., it sought an award from the CDC to implement several chronic disease programs). Another DPHHS partner is the Montana Healthcare Foundation, a nonprofit organization established in 2013. In addition to funding tribal-specific initiatives and convening American Indian health leaders throughout the year, the foundation regularly issues requests for proposals and has expanded support for mental health access and substance use treatment in Montana. All foundation-funded projects involve contracts with the DPHHS. Another frequent DPHHS partner is the Billings Area Indian Health Service, a U.S. Indian Health Service-funded agency addressing health care needs of tribal communities throughout Montana and Wyoming.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | Approximately $4.1 million for American Indian health activities across the three largest sources |
| Annual budget (FY 2015) of SMHE from state/territorial government | Approximately $175,000 |
| Largest funding source | USDA for WIC program for food |
| Anticipated changes to budget | None |

The DPHHS budget does not include a line item for the OAIH as it is included as part of the Director's Office budget. The OAIH's three largest funding sources include the U.S. Department of Agriculture, the tobacco master settlement agreement, and the CDC.

Specifically, FY 2015 awards included $2,300,000 for efforts supporting healthy foods and $750,000 for the Special Supplemental Nutrition Program for Women, Infants, and Children (U.S. Department of Agriculture); $775,000 for tobacco cessation efforts—of which $75,000 explicitly supports the Quit Line (tobacco master settlement agreement); and $250,000 for emergency preparedness support (CDC).

Other sources of funding are difficult to enumerate because the DPHHS budget does not separately identify funding for minority health activities. For example, as part of a global contract with the Montana Healthcare Foundation, the DPHHS provides approximately $50,000 to the Rocky Mountain Tribal Epidemiology Center for community health assessments. Montana's budget for minority health activities may change during the next 2 years if there are changes in federal funding.

# Montana

## Montana State Data

| Total Population[a]: 1,042,520 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 3.5 | 96.5 | 88.9 | 0.3 | 6.6 | 0.9 | 3.3 | 100.0 | NA |
| Percent of population medically uninsured[a] | 15.2 | 8.1 | 7.1 | 2.3 | 24.3 | 14.6 | 10.1 | 8.4 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 5.6 | 4.9 | SP | SP | SP | NC | 5.8 | 5.9 |
| Age-adjusted mortality rate[b] | 566.7 | 743.6 | 719.1 | 880.2 | 1176.8 | 398.8 | NC | 743.2 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 8.2 | 13.1 | 12.4 | SP | 21.0 | SP | 17.3 | 13.0 | 13.6 |
| Percent with diabetes[c] | 4.7 | 8.3 | 7.7 | SP | 15.9 | SP | 8.2 | 8.1 | 10.8 |
| Percent with heart disease[c] | 0.9 | 3.8 | 3.6 | SP | 3.64 | SP | 4.5 | 3.7 | 4.3 |
| HIV rate[d] | 132.4 | NC | 60.3 | 431.1 | 55.5 | 14.9** | 180.2 | 66.1 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 70.7 | 66.9 | 67.2 | SP | 66.3 | SP | 64.4 | 67.0 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 61.4 | 66.1 | 66.4 | SP | 64.0 | SP | 51.2 | 65.8 | 66.5 |
| Percent received flu vaccine[c] | 30.9 | 39.8 | 39.4 | SP | 40.8 | SP | 35.6 | 39.6 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

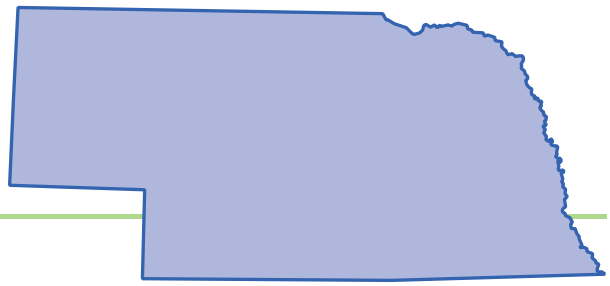
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 14.9 per 100,000 population (1 case); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 322.6 per 100,000 population (2 cases).

# Nebraska



## Introduction to Nebraska's Health Equity Activities

Nebraska had an estimated 2016 population of 1,907,000. Hispanics/Latinos are the largest racial-ethnic minority population (11 percent), followed by Blacks/African Americans (5 percent), Asian Americans and NHOPI (2 percent), and American Indians/Alaska Natives (1 percent). Persons self-identifying as multiracial or "other race" comprise 4 percent of the population.[1] Approximately 28,000 Nebraska residents live within a primary care health professional shortage area.[2]

The Nebraska Department of Health and Human Services (Nebraska DHHS) identifies its Office of Health Disparities and Health Equity (OHDHE) as its minority health entity. Envisioning "Nebraska's culturally diverse populations are as healthy as possible," the OHDHE's mission is to "promote and support the advancement of health equity in Nebraska using data, partnerships, funding, and training and technical assistance."[3] To this end, its efforts primarily focus on racial-ethnic minorities, American Indians, refugees, and immigrants.[4]

### Nebraska Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Health Disparities and Health Equity |
| Strategic plan in place to address minority health or health equity | The *Nebraska Department of Health and Human Services Division of Public Health Office of Health Disparities and Health Equity Strategic Plan* is updated periodically. |
| Date strategic plan was last updated | 2018 |
| Assessment plan in place to measure progress toward reducing health disparities | The strategic plan is updated annually to mark progress on objectives. Assessment plans are also part of the broader Nebraska Public Health Improvement Plan. |
| Key strategies used to achieve health equity | • Build capacity of organizations to develop best practices to advance health equity through training and technical assistance.<br>• Utilize data collection and analysis to inform stakeholders and advance health equity.<br>• Encourage and support partnerships to affect policies, systems, and programs that contribute to the promotion of health equity. |

## Organizational Structure

The Office of Health Disparities and Health Equity is housed within the Nebraska Department of Health and Human Services, Division of Public Health (DPH), Community and Rural Health Planning Unit. It has a central office in Lincoln and four satellite offices in Omaha, York, and Kearney. The OHDHE's advisory Minority Health Council meets at least quarterly and consists of up to 25 members appointed by the director of the Nebraska DHHS. These individuals range from consumers to providers and represent Nebraska's racial-ethnic minorities across the state's geographic regions.[5]

The OHDHE has 13 staff members, all of whom work full time on minority health and health equity initiatives.

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.
3 Nebraska Department of Health and Human Services Division of Public Health Office of Health Disparities and Health Equity. 2018-2021 Strategic Plan. Available on the Nebraska HHS website. Last accessed 8/27/2017.
4 Nebraska Department of Health and Human Services. Office of Health Disparities and Health Equity. Available on the Nebraska HHS website. Last accessed 6/19/2018.
5 Nebraska Department of Health and Human Services. Office of Health Disparities and Health Equity.

Staff members include an administrator, four health program managers, an epidemiologist, 2 community health educators, a data analyst, a program analyst, and a staff assistant. OHDHE team members often provide technical assistance to other divisions of the Nebraska DHHS. The OHDHE collaborates with the Centers for Disease Control and Prevention's public health associate program; three associates have assisted with minority health projects and initiatives. Given anticipated funding constraints, the OHDHE expects limited hiring over the next 2 years.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The OHDHE is housed within the Nebraska Department of Health and Human Services, Division of Public Health, Community and Rural Health Planning Unit. |
| SMHE staffing (full-time equivalents) | 11 |
| Advisory committee or panel | Minority Health Council |

## Program Goals and Activities

Available on its website, the OHDHE's current strategic plan (covering FY 2018–2021) lists the goals, focus areas, and outcomes the office is working towards. The OHDHE updates its strategic plan to indicate objectives accomplished each year. It also uses a dashboard to track and monitor the leading causes of mortality for each minority population at the state and local health department level.

The OHDHE's priorities are largely data driven and are developed with input from the Minority Health Council, community-based organizations, and other partners. Efforts to reduce health disparities, however, are not limited to the OHDHE—they are integrated into activities of offices and programs throughout the DPH. Examples include the DPH's plans addressing cancer, chronic disease, and maternal and child health identify disparities and strategies to reach minority and non-English speaking populations. Both the DPH's strategic plan and the Nebraska DHHS *Nebraska Public Health Improvement Plan* include health equity priorities with input from the OHDHE and its partners.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Division of Public Health | DPH |
| Office of Health Disparities and Health Equity | OHDHE |
| Nebraska Department of Health and Human Services | Nebraska DHHS |

Increasing cultural competency in health care has been a major focus of activity. The OHDHE provides in-person training and technical assistance on cultural intelligence, social determinants of health, and the National CLAS Standards to community organizations and staff throughout the Nebraska DHHS. It also collaborates with the DPH's Maternal Child Adolescent Health Program to expand education on the National CLAS Standards. Trainings can be requested via the OHDHE website, which also includes an educational video and links to additional resources. Additionally, the OHDHE sponsors a Minority Health Conference, where it also disseminates information on all its training opportunities.

Another OHDHE strategy for achieving health equity is to analyze quantitative data and prepare reports on the health and socioeconomic status of racial-ethnic minorities for use by other DPH divisions, local health departments, quality improvement organizations, federally qualified health centers (FQHCs), tribes, community-based organizations, and the public. It works closely with the state's four federally-recognized Native American tribes to improve the collection of tribe-specific data. For example, work is beginning on collaborative efforts with the tribes to publish health status report for each of the four tribes. The OHDHE also recently expanded data collection on the state's expanding refugee population and plans to publish a report on health status identified through a Behavior Risk Factor Surveillance Survey. Through a legislative mandate, the OHDHE also provides funding to address health disparities in minority populations in counties with minority populations of 5 percent or greater.

It also published in 2015 a Health Disparities Report documenting health status data of racial and ethnic minorities throughout the state.[6] Focusing on two 5-year time periods (2001–2005 and 2006–2010), the docu-

6 Nebraska Department of Health and Human Services. Nebraska Health Disparities: Executive Summary. September 2015. Available on the Nebraska HHS website. Last accessed 8/27/2017.

ment included a report card summarizing each racial and ethnic minority group's health and socioeconomic status, as well as charts illustrating Nebraska's progress on Healthy People 2010 objectives. The OHDHE plans to update the Health Disparities Report with a third 5-year timeframe to show trends and progress toward the Healthy People 2020 objectives.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Local public health departments<br>• Federally qualified health centers<br>• Community Cultural centers<br>• Federally recognized tribes<br>• Region VII Health Equity Council<br>• University of Nebraska Medical Center, University of Nebraska Minority Health Disparities Initiative, research initiatives, and councils |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

The OHDHE partners with local public health departments, FQHCs, and cultural centers through minority health initiative sub-awards and other grants. Nebraska's local public health departments function as independent entities and, through funding sub-awards, they collaborate with the ODHDE to improve the health of minorities in Nebraska through various evidence-based initiatives.

With funding through Nebraska's Native American Public Health Act and the Preventative Health and Health Services Block Grant funding, the OHDHE contracts with the state's four federally recognized tribes to assess needs and address both chronic disease and behavioral health issues. For example, the OHDHE is working with two tribes to address diabetes in American Indians in one Nebraska County. Without a formal contract, the OHDHE also works with the Great Plains Tribal Chairmen's Health Board to discuss and assess needs.

The OHDHE director and several members of the OHDHE Minority Health Council serve on the Region VII Health Equity Council, which has worked with the OHDHE to publish a heart disease disparities report for Region VII. This report highlights how African Americans and Native Americans are disproportionally affected by heart disease in Iowa, Kansas, Missouri, and Nebraska. The Region VII council also has a committee dedicated to developing partnerships with universities, physician associations, and other organizations; its efforts largely align with the health equity components of the *Nebraska State Health Improvement Plan* and Division of Public Health efforts. A regional health equity survey is currently being developed in partnership in the Region VII Health Equity Council and the Health Equity Priority Committee of the Nebraska State Health Improvement Plan.

The University of Nebraska at Lincoln has established a Minority Health Disparities Initiative (MHDI) with the OHDHE; its director sits on MHDI's advisory council and has presented at the university's annual Minority Health Disparities Initiative Conference on several occasions.

## Funding

| | |
|---|---|
| Annual budget (FY 2017) of state/territorial minority health entity (SMHE) across all income sources | $4,744,168 |
| Annual budget (FY 2017) of SMHE from state/territorial government | $4,133,168 |
| Largest funding source | State government |
| Anticipated changes to budget | Reductions anticipated in 2019 and 2020 |

In FY 2017, the OHDHE's total budget was $4,744,168; of that, $4,133,168 was allocated from state funding sources while federal contributions totaled $511,000. Reductions in state general funds allocated to the OHDHE may take place in 2019 and 2020 depending on tax revenues.

Federal funding sources for minority health in FY 2017 include a State Partnership Initiative to Address Health Disparities (SPI) grant from the U.S. Office of Minority Health ($197,209), a Preventive Health and Health Services Block internal funding grant ($278,000), and the Every Woman Matters internal funding screening program grant ($35,000). The SPI grant project award period runs from 2015 to 2020. The Every Women Matters funding is an internal allocation from the Every Women Matters program which has been awarded from 2015 to 2017.

# Nebraska

Support for the OHDHE's health disparities and health equity activities in FY 2017 break down as follows:

- **Minority health initiative state funding** ($1,526,000 cash funds, $31,713 general funds): The OHDHE provided funding for minority public health services in counties with a 5 percent or greater minority population, in Nebraska's first and third congressional districts. For 2015–2017, 19 projects received funding. Funded organizations included public health departments, FQHCs, tribes, community action agencies, and community-based organizations. A request for applications is published on a 2-year basis.
- **FQHC state funding** ($1,349,000 cash funds): The OHDHE distributed funds equally among FQHCs in the second congressional district to implement a minority health initiative targeting issues such as infant mortality, cardiovascular disease, obesity, diabetes, and asthma.
- **Native American Public Health Act state funding -** $500,000 ($450,000 general funds and $50,000 Preventative Health and Health Services Block Grant funding): The OHDHE funds four federally recognized tribes and one community-based organization to provide educational and public health services targeted to Native American populations.
- **Preventative Health and Health Services Block Grant:** OHDHE receives an internal allocation of from the Preventative Health and Health Services Block Grant funding received by the Nebraska Department of Health and Human Services Division of Public Health. The funding is allocated to:
  - Identify disparities among racial and ethnic minorities
  - Increase awareness of health disparities
  - Establish and maintain behavioral risk surveillance system for sub-groups of minority populations and refugees
  - Improve access to culturally competent and linguistically appropriate health services for racial and ethnic minorities
  - Improve data collection strategies for racial, ethnic and other vulnerable populations
  - Expand community-based health promotion and disease prevention outreach efforts to the aforementioned populations.

# Nebraska

## Nebraska State Data

| Total Population[a]: 1,907,116 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 10.6 | 89.4 | 88.0 | 4.7 | 0.8 | 2.4 | 4.1 | 100.0 | NA |
| Percent of population medically uninsured[a] | 22.5 | 7.1 | 7.8 | 17.7 | 26.7 | 6.6 | 15.9 | 8.7 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 6.7 | 5.3 | 4.8 | 11.5 | SP | SP | NC | 5.7 | 5.9 |
| Age-adjusted mortality rate[b] | 465.8 | 716.4 | 697.4 | 964.7 | 825.8 | 479.5 | NC | 707.0 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 8.4 | 12.8 | 12.3 | 21.8 | 10.2 | 6.7 | 9.1 | 12.4 | 13.6 |
| Percent with diabetes[c] | 6.3 | 9.0 | 8.6 | 12.3 | 12.5 | 6.1 | 9.4 | 8.8 | 10.8 |
| Percent with heart disease[c] | 0.4 | 4.1 | 4.1 | 3.4 | 4.0 | 1.1 | 0.9 | 3.8 | 4.3 |
| HIV rate[d] | 223.7 | NC | 82.8 | 836.7 | 186.5 | 88.4** | 269.8 | 131.6 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 58.6 | 67.0 | 66.8 | 69.3 | 55.4 | 62.0 | 60.3 | 66.4 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 56.9 | 70.2 | 71.0 | 54.4 | 54.0 | 64.8 | 54.0 | 69.2 | 66.5 |
| Percent received flu vaccine[c] | 38.4 | 45.1 | 45.1 | 36.7 | 42.3 | 47.3 | 40.1 | 44.5 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

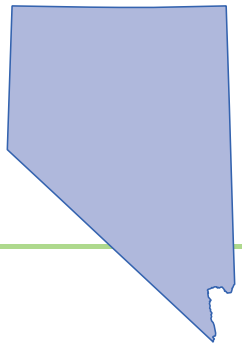
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 88.4 per 100,000 population (31 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 108.5 per 100,000 population (1 case).

# Nevada



## Introduction to Nevada's Health Equity Activities

Nevada had an estimated 2016 population of 2,940,000. Hispanics/Latinos are the largest racial-ethnic minority population (29 percent), followed by Blacks/African Americans (9 percent), Asian Americans and NHOPI (9 percent), and American Indians/Alaska Natives (1 percent). Persons self-identifying as multiracial or "other race" comprise 14 percent of the population.[1] Approximately 1,236,000 Nevada residents live within a primary care health professional shortage area.[2]

The Nevada Office of Minority Health was established during the 2005 legislative session. Following the loss of state general funds in 2010, the Nevada State Health Division transferred responsibility for minority health activities to the Office of Consumer Health Assistance. In July 2017, Assembly Bill 141 became law, reestablishing the office as the Office of Minority Health and Equity (OMHE) within the Department of Health and Human Services (Nevada DHHS). This new law also requires the Nevada DHHS and the State Board of Health to appoint nine voting members to a new stakeholder advisory committee. (Similarly, a nine-member advisory committee provided guidance to the former Office of Minority Health.) The OMHE is expected to become a member of the Nevada Minority Health and Equity Coalition, which local and state leaders established in 2016 to prioritize health disparities.

### Nevada Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Minority Health and Equity |
| Strategic plan in place to address minority health or health equity | The strategic plan that expired in 2014 has not yet been updated. |
| Date strategic plan was last updated | 2009 |
| Assessment plan in place to measure progress toward reducing health disparities | No |
| Key strategies used to achieve health equity | • Establishing the new Office of Minority Health and Equity<br>• Supporting the Minority Health and Equity Coalition<br>• Working to serve minority groups in addition to racial and ethnic minorities |

## Organizational Structure

After the Office of Minority Health lost its funding in 2010, minority health activities were managed by the Office of Consumer Health Assistance. Legislation enacted in 2017 established the new OMHE, which is housed within the Nevada DHHS and is staffed by a sole full-time staff member: the OMHE manager. The Nevada Minority Health and Equity Coalition ("Coalition") also supports the OMHE. With the new OMHE manager now overseeing both the OMHE and the Coalition, there is optimism that the OMHE will soon be better positioned to seek grants and other funding opportunities, which could lead to increased staffing in the next two years.

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Office of Minority Health and Equity is located within the Nevada Department of Health and Human Services. |
| SMHE staffing (full-time equivalents) | 1 |
| Advisory committee or panel | The nine-member advisory committee and the Nevada Minority Health and Equity Coalition |

## Program Goals and Activities

A 5-year strategic plan related to minority health and health equity was updated in 2009 and expired in 2014; it was not updated due to lack of funding. Following restoration of funding in 2017, a data-driven process for setting minority health and equity priorities is expected to be re-established and to include input from the Nevada Minority Health and Equity Coalition. The initial focus of the Nevada DHHS in 2017 has been to secure funding for both the OMHE and the Coalition, although it is also working to include within the OMHE's purview health disparities that affect persons with disabilities and members of Nevada's lesbian, gay, bisexual, and transgender communities.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Nevada Department of Health and Human Services | Nevada DHHS |
| Office of Minority Health and Equity | OMHE |

### Partnerships

| | |
|---|---|
| Primary collaborators | • Asian Community Development Center<br>• Asian Community Resource Center<br>• CARE Coalition<br>• Community Partners for Better Health<br>• Division of Public and Behavioral Health<br>• Nevada Donor Network<br>• Planned Parenthood<br>• Southern Nevada Health District<br>• Silver State Health Insurance Exchange<br>• University of Nevada, Las Vegas |
| Contracts or memoranda of understanding with any partners | No partnerships include formal contracts or memoranda of understanding. |

Efforts to re-establish a dedicated state minority health entity have involved several governmental and nongovernmental agencies and organizations, including the University of Nevada, Las Vegas School of Community Health Sciences, the Southern Nevada Health District, the Silver State Health Insurance Exchange, and the Nevada DHHS Division of Public and Behavioral Health. Nonprofit organizations involved in the process include the Asian Community Resource Center, the CARE Coalition (which focuses on substance abuse and mental health), Community Partners for Better Health, the Nevada Donor Network, and Planned Parenthood.

The University of Nevada, Las Vegas School of Community Health Sciences received funding from the Nevada DHHS to assist in establishing the Nevada Minority Health and Equity Coalition. Meanwhile, the Nevada DHHS' partnership with the Silver State Health Insurance Exchange provided enrollment support, as well as educational support to the provider community regarding the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). The Division of Public and Behavioral Health will also help ensure the availability of suitable educational materials to support implementation of the National CLAS Standards.

All of the nonprofit agencies that serve as partners with the OMHE are participants in the Minority Health and Equity Coalition. Planned Parenthood and the CARE Coalition have expressed interest in leadership roles with the coalition and many of the other partners have offered to provide space for meeting locations.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $0 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $0 |
| Largest funding source | State funding for the OMHE resumed in July 2017. |
| Anticipated changes to budget | None beyond the 2017 resumption of funding |

Although the OMHE did not yet exist in FY 2015, the DHHS provided approximately $30,000 to the University of Nevada, Las Vegas to create the Nevada Minority Health and Equity Coalition. The 2017 legislation provided approximately $133,000 per year from Nevada general funds for the OMHE and the coalition. No additional budget changes are expected.

# Nevada

## Nevada State Data

| Total Population[a]: 2,940,058 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 28.5 | 71.5 | 66.8 | 8.9 | 1.1 | 9.0 | 14.2 | 100.0 | NA |
| Percent of population medically uninsured[a] | 20.9 | 7.5 | 10.4 | 9.5 | 15.7 | 8.2 | 18.3 | 11.3 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 4.8 | 5.5 | 4.3 | 9.2 | SP | SP | NC | 5.2 | 5.9 |
| Age-adjusted mortality rate[b] | 453.9 | 817.3 | 789.3 | 843.0 | 575.8 | 450.6 | NC | 762.6 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 8.2 | 12.7 | 11.8 | 14.9 | 6.8 | 12.2 | 9.6 | 11.7 | 13.6 |
| Percent with diabetes[c] | 9.2 | 11.8 | 11.2 | 16.6 | 10.1 | 7.8 | 10.0 | 11.1 | 10.8 |
| Percent with heart disease[c] | 2.0 | 5.1 | 5.3 | 5.3 | 1.5 | 2.9 | 1.8 | 4.4 | 4.3 |
| HIV rate[d] | 359.3 | NC | 307.7 | 1068.0 | 238.1 | 132.0** | 441.2 | 371.0 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 62.8 | 72.7 | 71.8 | 80.9 | 51.4 | 65.9 | 63.9 | 70.3 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 51.8 | 64.4 | 65.3 | 61.8 | 61.6 | 54.9 | 50.1 | 61.3 | 66.5 |
| Percent received flu vaccine[c] | 22.5 | 35.3 | 35.5 | 20.7 | 24.9 | 46.7 | 22.4 | 32.8 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

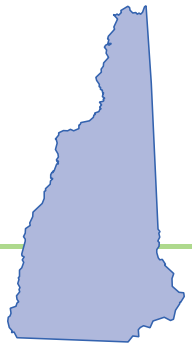
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 132.0 per 100,000 population (271 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 231.5 per 100,000 population (33 cases).

# New Hampshire



## Introduction to New Hampshire's Health Equity Activities

New Hampshire had an estimated 2016 population of 1,335,000. Hispanics/Latinos are the largest racial-ethnic minority population (3 percent), followed by Asian Americans and NHOPI (3 percent), Blacks/African Americans (1 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 3 percent of the population.[1] Approximately 117,000 New Hampshire residents live within a primary care health professional shortage area.[2]

### New Hampshire Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Health Equity |
| Strategic plan in place to address minority health or health equity | Yes. The Office of Health Equity co-led the New Hampshire Health and Equity Partnership's efforts to create the *Plan to Address Health Disparities and Promote Health Equity in New Hampshire*. |
| Date strategic plan was last updated | 2011 |
| Assessment plan in place to measure progress toward reducing health disparities | The New Hampshire plan includes goals and assessment components to measure progress. |
| Key strategies used to achieve health equity | • Collaborating to increase awareness and understanding about health equity<br>• Promoting implementation of cultural and linguistic standards<br>• Promoting Community Health Workers and workforce diversity<br>• Collaborating through the New Hampshire Health and Equity Partnership<br>• Facilitating the Culturally Effective Organizations Priority Work Group<br>• Facilitating the Behavioral Health Equity Work Group<br>• Collaborating with the Division of Public Health Services to increase access to services<br>• Assisting with the Equity Leaders Fellowship<br>• Increasing awareness and understanding about race, ethnicity and language (REaL) data collection and use |

The Office of Health Equity (OHE) within the New Hampshire Department of Health and Human Services (DHHS) is the state agency devoted to health disparities and related issues. The OHE is housed within the Office of the Commissioner to reflect the cross-divisional importance of the OHE priorities, policies and initiatives, and its key supportive function to the entire Department. In New Hampshire, the Division of Public Health Services is a part of the DHHS, as are Medicaid, the Division for Children Youth and Families, the Division of Family Assistance, the Bureau of Behavioral Health, and more. The DHHS had established the Office of Minority Health in 1999 to improve minority health and safeguard all New Hampshire residents' access to services; in 2010, it integrated the New Hampshire Refugee Program to create the Office of Minority Health and Refugee Affairs; in 2016, the office was renamed the OHE (for simplicity, the name used throughout this summary). The OHE assures equitable access to effective, quality DHHS programs and services across all populations, with specialized focus on racial, ethnic, language, gender and sexual minorities, and individuals with disabilities.

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

## Organizational Structure

Although it does not have a formal advisory committee or panel, the OHE seeks input on initiatives and activities from community-based organizations, community leaders, other partners and stakeholders, and state agencies.

Of the OHE's 10 staff positions, 3 work exclusively on health equity: the OHE's director, administrative secretary, and minority health program specialist (vacant). Three other staff members work on improving minority health and health equity by their focus on cultural and linguistic competence: the DHHS communication access coordinator; the hearing, speech and vision program specialist; and the cultural and linguistic competence coordinator. The three state refugee program staff (coordinator, health coordinator, and program specialist) also contribute towards advancing cultural and linguistic competence and workforce diversity.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The OHE is housed within the New Hampshire Department of Health and Human Services |
| SMHE staffing (full-time equivalents) | 10 |
| Advisory committee or panel | None |

## Program Goals and Activities

The OHE engages in many strategies to improve the health of minority populations. In 2011, the OHE co-founded the public-private New Hampshire Health and Equity Partnership to create a strategic plan, the *Plan to Address Health Disparities and Promote Health Equity in New Hampshire*. This document identified the following strategic priority areas: access to care; addressing environments where we live, learn, work and play; awareness and promotion of health equity; and improving data collection and use to identify and monitor disparities. In 2014, the partnership began to align with a collective impact approach and identified three priority areas on which to focus efforts:

- Increase the capacity in the state for the collection of high quality Race, Ethnicity and Language (REaL) data across all systems at the state and local level to identify disparities and promote utilization of data to inform improvements, policies and procedures.
- Increase organizational cultural effectiveness and improve the capacity of organizations in the state to provide high quality services to all populations (especially racial, ethnic, and linguistic minorities) by incorporating the elements of a culturally effective organization.
- Increase a diversified workforce to support economic opportunities for racial, ethnic, and linguistic minorities and all populations in the state.

While the OHE relies upon such data to guide its decision-making, its priorities are also determined based on available federal and state funding.

Another strategy is to leverage opportunities to collaborate with organizations to increase awareness of health equity issues. Together with the New Hampshire Department of Education, for example, the OHE is promoting implementation of cultural and linguistic standards. It also collaborates with the Division of Public Health Services to increase access to services and assists with the Southern New Hampshire Area Health Education Center's Equity Leaders Fellowship. Staff with the OHE also facilitate several workgroups, such as the Health and Equity Partnership's Culturally Effective Organizations Work Group and the Behavioral Health Equity Work Group, a joint effort of the New Hampshire Health and Equity Partnership and the New Hampshire Children's Behavioral Health Collaborative.

Sharing information is another core strategy the OHE employs to increase health equity. The OHE director speaks at different conferences and to various organizations, tailoring remarks for each audience. Topics of recent talks include: the importance of collection of race, ethnicity, and language (REaL) data; social determinants of health and demographics; and the impact of health equity work in New Hampshire.

The OHE had previously received a State Partnership Grant Program to Improve Minority Health (SPG) grant from the U.S. Office of Minority Health. It used this funding to develop a train-the-trainer initiative for community-connected organizations and consumer assistance entities designated by the New Hampshire Insurance Department. These trainers worked to increase awareness of health insurance options for underserved and minority populations. Relatedly,

the OHE also trained five access outreach workers to conduct culturally- and linguistically-appropriate information sessions about the Patient Protection and Affordable Care Act, and the health insurance marketplace for uninsured minority and other underserved populations.[3] The SPG award also helped strengthen partnerships between the OHE and other agencies and organizations working to promoting health equity, including partially funding development of the *Plan to Address Health Disparities and Promote Health Equity in New Hampshire*.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| New Hampshire Department of Health and Human Services | DHHS |
| Office of Health Equity | OHE |

From 2010 to 2015, the OHE received almost $12 million in federal Administration for Children and Families Health Profession Opportunity Grant (HPOG) funds for its New Hampshire Health Profession Opportunity Project. HPOG's objectives were to train Temporary Assistance for Needy Families and other low-income individuals in health occupations that pay well and are projected to be in high demand, as well as to offer advancement opportunities for those already engaged in health careers. Partners included the Division of Family Assistance (DFA), the Department of Labor (DOL) Apprenticeship Office, the Office of Workforce Opportunity/Workforce Investment Board (OWO/WIB), and multiple contractors, supporters, advisers, and stakeholders. After 5 years, NH's HPOG outcomes include: 1,311 participants enrolled; 1,051 enrolled in health care training; 845 participants completed health care training; 782 individuals employed; and 692 employed in health care. An additional objective was promoting workforce diversity; the OHE exceeded its target of 25 percent minority enrollment with 28 percent of participants reflecting racial/ethnic diversity.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Behavioral Health Equity Workgroup<br>• Division of Public Health Services<br>• Brandeis Institute on Assets and Social Policy<br>• Foundation for Healthy Communities<br>• Immigrant Integration Network<br>• New Hampshire Children's Behavioral Health Collaborative<br>• New Hampshire Department of Education<br>• New Hampshire Department of Health and Human Services<br>• New Hampshire Endowment for Health<br>• New Hampshire Health and Equity Partnership<br>• New Hampshire Multicultural Student Affairs Consortium<br>• Southern New Hampshire Area Health Education Center<br>• Numerous ethnic community-based organizations |
| Contracts or memoranda of understanding with any partners | No partnerships include formal contracts or memoranda of understanding. |

To further its mission of reducing health disparities, the OHE collaborates with many organizations and networks (e.g., Children's Behavioral Health Collaborative, the New Hampshire Multicultural Student Affairs Consortium, and the Immigrant Integration Network). Within the state government, it partners with other programs within the DHHS and the Division of Public Health Services. For example, the OHE provides input and resources to state government efforts around health equity issues such as increasing minority populations' access to services like home visits, breast and cervical cancer screenings, and maternal and child health care. The OHE also monitors meetings across the Division and provides input and resources related to health equity.

3 Information about New Hampshire's State Partnership Grant is available on the U.S. Department of Health and Human Services, Office of Minority Health website. Last accessed 7/14/2017.

One of its most high-profile collaborations is with the many partners involved in the public-private New Hampshire Health and Equity Partnership, as well as the host-agency, the Foundation for Healthy Communities. Comprised of advocates, community-based organizations, public health agencies, and philanthropic organizations, the Partnership published in 2011 its *Plan to Address Health Disparities and Promote Health Equity in New Hampshire*.[4] Building on the recommended strategic areas outlined in the plan, the Partnership recently developed three priorities: implement culturally effective organizations, promote workforce diversity, and promote the collection and use of race, ethnicity, and language (REaL) data.

As a result of the Health Profession Opportunity Project initiative, the OHE partnered with the ACF/HPOG-funded Brandeis Institute on Assets and Social Policy's New Hampshire Employer Research Initiative. This collaboration significantly advanced the state's understanding of employer perspectives, as well as strategies to promote workforce diversity.[5] Multiple publications resulted, including the *Culturally Effective Healthcare Organizations: A Framework for Success Issue Brief*,[6] co-authored by the OHE director, and foundational to much of OHE's work.

The OHE works informally with the Southern New Hampshire Area Health Education Center (SNH AHEC), a community-based nongovernmental organization focused on underserved communities.[7] Since 2001, this center has operated an interpretation training program accredited by the New Hampshire Department of Education; it also offers trainings on health care community interpretation, legal interpretation, medical interpretation, behavioral health interpretation, and infectious disease interpretation.[8,9] The OHE and the SNH AHEC worked together to create interpretation trainings for behavioral health and infectious disease; they also partner on efforts to promote community health workers in the state. Additionally, the OHE director helped create the Equity Leaders Fellowship, which is administered by the SNH AHEC. By offering learning sessions on leadership development, one-on-one mentoring, and a board shadowing experience, this fellowship prepares individuals from communities of color to serve on nonprofit boards, join community committees, and participate in other civic engagement opportunities. Another informal OHE partner on many of its minority health activities is the New Hampshire Endowment for Health—a private, nonprofit foundation that operates statewide to "improve the health of New Hampshire's people, especially those who are vulnerable and underserved."[10]

As noted above, OHE staff also facilitate the Behavioral Health Equity Workgroup, a joint effort of the New Hampshire Health and Equity Partnership and the New Hampshire Children's Behavioral Health Collaborative. Through this workgroup, the OHE provides technical assistance and coaching resources addressing cultural and linguistic competence and implementation of the National CLAS Standards. Relatedly, the OHE seeks to increase behavioral health equity awareness and understanding by facilitating discussions around many topics, including the collection of data on race, ethnicity, language, sexual orientation, gender identity information, and language access.

The OHE also informally partners with the New Hampshire Department of Education to implement the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). In connection with grants that the department received recently from the Substance Abuse and Mental Health Services Administration, the OHE assists grantees in understanding and applying the National CLAS Standards. The OHE also helped the New Hampshire Department of Education develop a training video, *Understanding and Practical Implementation of CLAS Standards*.[11]

4 *Plan to Address Health Disparities and Promote Health Equity in New Hampshire*. Available on the New Hampshire DHHS website. Last accessed 7/14/2017.
5 More information is available at the Brandeis University Heller School's website. Last accessed 7/14/2017.
6 Culturally Effective Healthcare Organizations: A Framework for Success." Institute on Assets and Social Policy, Heller School for Social Policy and Management. Brandeis University, Waltham, MA. April 2015. Available on the Brandeis University Heller School website. Last accessed 6/19/2018.
7 More information is available from the Southern New Hampshire Area Health Education Center website. Last accessed 7/14/2017.
8 *Fifteen Years of Interpretation Training*. Available at the Southern New Hampshire Area Health Education Center's website. Last accessed 7/14/2017.
9 The Trained Interpreters List is available at the Southern New Hampshire Area Health Education Center's website. Last accessed 7/14/2017.
10 "About Endowment for Health." Available at the Endowment for Health website. Last accessed 7/14/2017.
11 National Resource Center for Mental Health Promotion & Youth Violence Prevention. Understanding and Practical Implementation of CLAS Standards.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $5,243,233 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $160,954 |
| Largest funding source | U.S. HHS Administration for Children and Families, Health Profession Opportunity Grants Initiative |
| Anticipated changes to budget | HPOG funding ending |

Supported with a mix of state and federal funding, the OHE had a FY 2015 budget of over $5 million. This includes a $132,826 through a SPG grant from the U.S. Office of Minority Health.[12] The OHE did not receive SPG funding after FY 2015, nor does it anticipate budget changes in the next 2 years.

12 Information about New Hampshire's State Partnership Grant is available on the U.S. Department of Health and Human Services, Office of Minority Health website. Last accessed 7/14/2017.

# New Hampshire

## New Hampshire State Data

| Total Population[a]: 1,334,689 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 3.6 | 96.4 | 93.2 | 1.2 | 0.1 | 2.6 | 2.8 | 100.0 | NA |
| Percent of population medically uninsured[a] | 8.8 | 6.3 | 6.3 | 20.3 | 1.5 | 6.9 | 4.6 | 6.4 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 3.9 | 4.1 | SP | SP | SP | NC | 4.1 | 5.9 |
| Age-adjusted mortality rate[b] | 282.4 | 726.7 | 729.9 | 493.4 | SP | 386.5 | NC | 721.5 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 29.2 | 16.1 | 16.4 | 9.3 | 12.2 | 11.2 | 24.8 | 16.3 | 13.6 |
| Percent with diabetes[c] | 10.2 | 9.0 | 9.2 | 3.1 | 7.4 | 5.1 | 8.1 | 9.0 | 10.8 |
| Percent with heart disease[c] | 3.0 | 4.2 | 4.2 | 4.3 | 8.0 | 0.6 | 4.3 | 4.2 | 4.3 |
| HIV rate[d] | 485.0 | NC | 82.4 | 1089.5 | 0.0 | 38.6** | 351.1 | 107.6 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 80.0 | 73.9 | 74.1 | 84.8 | 51.5 | 79.1 | 66.4 | 73.9 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 75.8 | 72.1 | 72.5 | 67.0 | 69.8 | 82.7 | 54.8 | 72.2 | 66.5 |
| Percent received flu vaccine[c] | 30.7 | 42.0 | 42.4 | 25.3 | 31.6 | 36.3 | 33.9 | 41.8 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

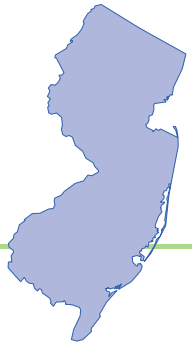
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 38.6 per 100,000 population (11 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 0.0 per 100,000 population (0 cases).

# New Jersey



## Introduction to New Jersey's Health Equity Activities

New Jersey had an estimated 2016 population of 8,945,000. Hispanics/Latinos are the largest racial-ethnic minority population (20 percent), followed by Blacks/African Americans (13 percent), Asian Americans and NHOPI (10 percent), and American Indian/Alaska Native (less than 1 percent).[1] Approximately 29,000 New Jersey residents live within a primary care health professional shortage area.[2]

In 1992, New Jersey established the Office of Minority and Multicultural Health (OMMH) in accordance with Public Law 1991, Chapter 401. Its mission is to "reduce and ultimately eliminate racial, ethnic health disparities by fostering equal access to programs that promote, support and enable all populations in New Jersey to achieve optimal health, dignity and independence."[3]

### New Jersey Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | New Jersey Department of Health, Office of Minority and Multicultural Health |
| Strategic plan in place to address minority health or health equity | *Healthy New Jersey 2020*[4] |
| Date strategic plan was last updated | In process |
| Assessment plan in place to measure progress toward reducing health disparities | Performance measures are included in the Strategic Plan |
| Key strategies used to achieve health equity | • Community Health Disparity Prevention Program<br>• Regional Health Equity Forums<br>• Community Outreach<br>• New Jersey Department of Health website |

## Organizational Structure

In 1992, legislation established the New Jersey OMMH as the sole office responsible for addressing minority health, health disparities, and health equity issues in the state. It resides within the New Jersey Department of Health, Division of Policy and Strategic Planning. The OMMH has five full-time employees dedicated to minority health and health disparity initiatives. The office's executive director reports to the commissioner of the New Jersey Department of Health and is considered a part of its executive staff. Additional full-time staff includes two program specialists, one public health representative, and one executive secretary. The office does not use volunteers for its activities and initiatives, but often engages unpaid student interns. In 2014, the OMMH began a program with Rutgers University that matches a Master of Public Health student with an OMMH grantee in the community. The student receives practical, hands-on experience and helps the OMMH influence the public health workforce.

The Office of the Commissioner maintains the OMMH Advisory Commission, composed of up to nine members representing community sectors such as health care facilities, health care professions, and the health insurance industry. The Governor, the Speaker of the General Assembly, or the President of the Senate may

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 New Jersey Department of Health Website. Last accessed 6/16/2016.

4 Healthy New Jersey 2020. State of New Jersey Department of Health Website. 2016. Last accessed 1/13/2018.

appoint New Jersey residents to the advisory commission for a 3-year term. The commission meets on a quarterly basis to review and make recommendations on rules, regulations, and policies that the OMMH proposes. The Commission also advises the OMMH on grant awards, program and service development, and needs and priorities of minorities in New Jersey.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The OMMH is housed within the New Jersey Department of Health, Division of Policy and Strategic Planning |
| SMHE staffing (full-time equivalents) | 5 |
| Advisory committee or panel | OMMH Advisory Commission |

## Program Goals and Activities

New Jersey addresses strategies regarding minority health, health disparities, and health equity in *Healthy New Jersey 2020*, the State Health Improvement Plan. In that Plan, New Jersey identifies statewide health improvement priorities, increases public awareness and understanding of the determinants of health, provides measureable objectives and goals, engages multiple stakeholders to strengthen policies and improve practices, and identifies critical research, evaluation, and data collection needs. The Plan focuses on five of the state's major public health concerns: access to primary care, birth outcomes, childhood immunization, heart disease, and obesity. The New Jersey OMMH is collaborating with other New Jersey Department of Health offices to update the plan for 2016–2020.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| New Jersey Department of Health | NJDOH |
| Office of Minority and Multicultural Health | OMMH |

The state is implementing many activities and initiatives to reduce health disparities and improve health equity. The OMMH runs the *Community Health Disparity Prevention Program*, a mini-grant program in which funded programs use evidence-based strategies or promising practices to reduce health disparities for a targeted population within the community. The grantees are required to provide activities to the community during National Minority Health Month. The OMMH provides funding to a wide variety of organizations, such as faith-based institutions, community organizations, local public health centers, federally qualified health centers (FQHCs), hospital-based programs, United Way organizations, and YMCAs. For example, the OMMH funded *Faithful Families Eating Smart and Moving More*, an obesity prevention program originally developed in North Carolina that promotes healthy eating and physical activity in faith-based communities.

Community outreach and funding for community initiatives are essential strategies that the OMMH uses to address health disparities. The OMMH also sponsors regional health equity forums, free to the public, and usually held in April in conjunction with National Minority Health Month. Specifically, the OMMH sponsors three regional health equity forums—one in the northern, central, and southern regions of the state. At these forums, community partners present initiatives funded through the *Community Health Disparity Prevention Program* and discuss their progress (noting which performance metrics they have used), outcomes, barriers, strategies, and lessons learned. On average, each year, OMMH conducts six to eight forums that are open to the public.

The Cook/Rutledge Fellowship is one of the longest-running community outreach endeavors of the OMMH. New Jersey students who are enrolled in a graduate school program in medicine, law, or public health can apply for 10-week summer fellowships that involve working on a joint OMMH/university project related to minority health and health disparities. Past fellowship projects have included implementing the National Standards for Culturally and Linguistically Appropriate Services (National CLAS Standards) in long-term-care facilities, identifying and assessing food deserts, and producing health data and information on minority populations. On average, two students receive fellowships each year; a $6,000 stipend is contingent upon availability of state funds.

Another key part of OMMH's community outreach involves giving educational presentations at conferences or symposia about health disparities or related topics. The OMMH also sponsors its own summits or conferences. In December 2015, it hosted a forum for the Hepatitis B Coalition, a statewide coalition of community organizations and hospitals focused on health care in the Asian population. At the forum, coalition members and other interested individuals discussed programs in New Jersey that target the Asian population.

To educate New Jersians about minority health and health disparities, the OMMH disseminates information via the New Jersey Department of Health website.[5] The website includes a "Your Health" tab, enabling users to access information about multicultural health, including: cultural competency, minorities in health professions, and community outreach activities. Users can also view health assessment data about the state's progress on leading health indicators in relation to race and ethnicity.

### Partnerships

| | |
|---|---|
| Primary collaborators | • New Jersey local public health offices<br>• Federally qualified health centers (FQHCs)<br>• Rutgers University<br>• OMMH database of collaborators |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

OMMH partners with governmental and nongovernmental agencies and organizations. It maintains a strong relationship with New Jersey local public health offices to support minority health and promote activities to reduce health disparities. In 2011, it restructured the *Community Health Disparity Prevention Program* to include funding for local public health office programs. These programs provide funding to grantees that have a documented relationship with their local public health office (e.g., through a memorandum of understanding). Additionally, the OMMH maintains relationships with the New Jersey Primary Care Association, which represents 22 FQHCs and 129 satellite community-based ambulatory health care facilities throughout New Jersey. The FQHCs are included in all of the office's community outreach activities. FQHC staff, CEOs, and physicians also serve on OMMH's advisory committees, groups, and in other initiatives.

Rutgers University is another major collaborator. The OMMH regularly taps into the University's resources, such as the Rutgers' Center for State Health Policy, which often conducts basic program evaluations and analyzes survey findings for the OMMH. Rutgers also offers many community-focused activities, including those through its Urban Center for Families; at the time of this writing, the OMMH was funding three Urban Center for Families' programs.

Another important collaboration between the OMMH and Rutgers involves the African-American Brain Health Initiative: A University-Community Partnership. Under this project, in August 2015, the OMMH and Rutgers University received a grant from the U.S. Office of Minority Health to implement interventions for older African Americans living in the low-income urban neighborhoods of greater Newark to reduce health disparities in mental health and physical activity. Together they have rolled out community programs to get more African Americans engaged in physical activity, healthy eating, and mental well-being.

In addition to the collaborators listed above, the OMMH maintains a database of over 1,000 contacts that it uses to disseminate information about minority health and health disparities at community events (e.g., health fairs and conferences). The database includes schools, hospitals, FQHCs, local public health centers, churches, charitable organizations, and other community-based organizations.

## Funding

| | |
|---|---|
| Annualized budget (FY 2014) of state/territorial minority health entity (SMHE) across all income sources | $1,500,000 |
| Annual budget (FY 2014) of SMHE from State/territorial government | State initiatives |
| Largest funding source | State government |
| Anticipated changes to budget in FY 2015 | No |

The total FY 2014 funding for the New Jersey OMMH was $1,500,000. In 2014, the office was funded solely through the State of New Jersey; in FY 2015, OMMH also received grant funds from the U.S. Office of Minority Health.

5 See the New Jersey Department of Health Website. Last accessed 1/13/2018.

# New Jersey

## New Jersey State Data

| Total Population[a]: 8,944,469 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 20.0 | 80.0 | 68.2 | 13.4 | 0.2 | 9.6 | 8.6 | 100.0 | NA |
| Percent of population medically uninsured[a] | 19.6 | 5.0 | 6.4 | 9.2 | 18.6 | 6.7 | 18.6 | 7.9 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 4.6 | 4.7 | 3.7 | 9.5 | SP | 3.2 | NC | 4.7 | 5.9 |
| Age-adjusted mortality rate[b] | 455.0 | 694.1 | 680.1 | 789.2 | 140.8 | 311.9 | NC | 668.5 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 14.6 | 11.4 | 11.5 | 14.7 | 10.0 | 10.4 | 14.0 | 12.1 | 13.6 |
| Percent with diabetes[c] | 9.6 | 9.0 | 8.3 | 14.9 | 6.9 | 6.3 | 9.1 | 9.1 | 10.8 |
| Percent with heart disease[c] | 3.8 | 4.0 | 4.0 | 4.2 | 2.2 | 2.4 | 4.4 | 3.9 | 4.3 |
| HIV rate[d] | 723.6 | NC | 158.0 | 1674.2 | 103.0 | 44.0** | 2665.6 | 473.7 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 79.3 | 79.7 | 79.0 | 86.7 | 64.9 | 72.0 | 84.8 | 79.4 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 65.3 | 76.5 | 77.4 | 67.9 | 59.3 | 74.4 | 69.2 | 74.8 | 66.5 |
| Percent received flu vaccine[c] | 34.0 | 40.7 | 40.9 | 36.9 | 38.6 | 38.5 | 34.3 | 39.5 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

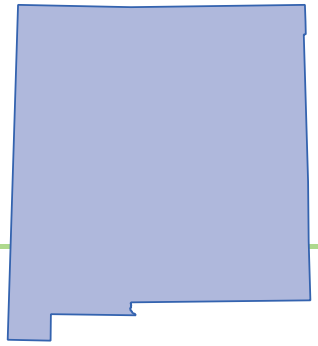
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 44.0 per 100,000 population (310 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 372.1 per 100,000 population (9 cases).

# New Mexico



## Introduction to New Mexico's Health Equity Activities

New Mexico had an estimated 2016 population of 2,081,000. Hispanics/Latinos are the largest racial-ethnic minority population (48 percent), followed by American Indians/Alaska Natives (9 percent), Blacks/African Americans (2 percent), and Asian Americans and NHOPI (1 percent). Persons self-identifying as multiracial or "other race" comprise 12 percent of the population.[1] Approximately 1,048,000 New Mexico residents live within a primary care health professional shortage area.[2]

New Mexico established the Office of Health Equity (OHE) to address health disparities throughout New Mexico. Since racial and ethnic groups served by the OHE comprise a majority of the state's population, the OHE tends to describe its goals and activities in terms of health equity and health disparities rather than minority health. The Health Equity Workgroup (HEWG), consisting of 19 members from all divisions within the Department of Health (DOH), advises the OHE on minority health, health equity, and health disparities. The HEWG has worked to support the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). The objectives of the HEWG include ongoing assessment of DOH health equity initiatives, development and administration of the annual National CLAS Standards assessment, providing feedback for the annual health equity report, and identifying opportunities for collaboration on DOH health equity initiatives. Some of the OHE's most important partnerships are with other groups and programs within the DOH and supported through the HEWG.

### New Mexico Minority Health Overview

| | |
|---|---|
| Name of state/territorial minority health entity | Office of Health Equity |
| Strategic plan in place to address minority health or health equity | The DOH strategic plan emphasizes health equity, given that racial and ethnic minorities constitute a majority of the population. |
| Date strategic plan was last updated | 2018 |
| Assessment plan in place to measure progress toward reducing health disparities | Yes, DOH uses a performance management system framework to measure progress. |
| Key strategies used to achieve health equity | • Providing medical interpreter training to staff, offering Public Health Spanish, and training staff department-wide on cultural competency<br>• Collecting, analyzing, and reporting data on disparities among racial and ethnic minorities and expanding focus to look more broadly at data related to determinants of health<br>• Developing a health literacy coalition with statewide stakeholders |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

## Organizational Structure

The OHE is part of the Office of Policy and Accountability under the Administrative Services Division, which is one of eight DOH divisions. The director of the Office of Policy and Accountability reports directly to one of the Deputy Secretaries of the DOH. Along with the OHE, the Office for Border Health and the Office of the Tribal Liaison are part of the Office of Policy and Accountability, and these offices frequently collaborate.

The OHE has three full-time staff, including the director, an education and outreach coordinator, and a translator. Another translator works half-time in the OHE. Student interns occasionally assist with OHE activities. Staffing allocations are not expected to change over the next 2 years.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Office of Health Equity is part of the Office of Policy and Accountability within the Administrative Services Division of the Department of Health. The director of the Office of Policy and Accountability reports to the Deputy Secretary of the Department of Health, who is an appointee of the governor. |
| SMHE staffing (full-time equivalents) | 3.5 |
| Advisory committee or panel | Health Equity Workgroup |

## Program Goals and Activities

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Department of Health | DOH |
| Health Equity Workgroup | HEWG |
| Office of Health Equity | OHE |

The New Mexico DOH has a 3-year strategic plan (currently covering 2017–2019), which it updates annually. The plan focuses on health equity goals. Although the OHE is actively involved in developing this document, it does not have its own standalone strategic plan. The OHE publishes a health equity report that delivers timely and relevant information about the comparative health status of New Mexico's populations by analyzing data from the Epidemiology and Response Division to identify disparities. While the OHE does not have a comprehensive plan to assess progress on its disparities reduction activities, its health equity report does demonstrate improvements.

Some of the OHE's strategies for reducing health disparities and achieving health equity include:

- Workforce training in a new Public Health Spanish course and Spanish Medical Terminology and Interpretation.
- Building an awareness of a disease (cerebral cavernous angioma) which is caused by a genetic mutation traced to a family that settled in New Mexico in the early 1600's and potentially could affect many Hispanic families.
- Participation on the New Mexico Office of African American Affairs' New Mexico Birth Equity Collaborative strategically addressing that Black or African American women continue to have a higher percentage of LBW infants and the highest infant mortality rates (11.8 per 1,000 live births in 2013–2015)
- Supporting the Office of Primary Care and Rural Health in leading a team of diverse stakeholders to develop a current statewide rural health plan and assess rural healthcare workforce initiatives in New Mexico.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Healthy Kids, Healthy Communities participating organizations<br>• ONAPA<br>• Office of School and Adolescent Health<br>• Office of Primary Care and Rural Health |
| Contracts or memoranda of understanding with any partners | Yes, contracts are implemented for some partnerships (e.g., for interpreter training on the Navajo Nation and health literacy projects). |

The OHE does not have contracts or memoranda of understanding in place with most external partners. Contract activities are determined on an annual basis. However, it has held two formal, contractual partnerships: one with an individual who conducts annual medical terminology trainings for Navajo Nation interpreters, and a second supporting the creation of a health literacy coalition.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $175,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $175,000 |
| Largest funding source | State government |
| Anticipated changes to budget | None |

The total FY 2015 funding for the OHE was approximately $175,000 to support staff positions. However, the OHE receives a portion of the funding allocated to the Office of Policy and Accountability from a 5-year Federal Preventive Health and Health Services Block Grant, in the amount of $214,853. That funding varies depending on planned activities for each year, and supports the OHE's health literacy efforts, including the Navajo medical interpreter training, other health literacy contracts, National CLAS Standards training, and other related activities. Sources and amounts of funding may change in the future if the OHE is awarded additional grants.

# New Mexico

## New Mexico Data

| Total Population[a]: 2,081,015 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 48.6 | 51.5 | 73.3 | 2.0 | 9.4 | 1.7 | 13.6 | 100.0 | NA |
| Percent of population medically uninsured[a] | 10.8 | 7.9 | 7.8 | 9.1 | 20.8 | 3.9 | 10.3 | 9.3 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 4.4 | 5.6 | 4.7 | SP | 6.7 | SP | NC | 5.1 | 5.9 |
| Age-adjusted mortality rate[b] | 727.7 | 766.8 | 743.4 | 672.5 | 887.6 | 428.3 | NC | 753.4 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 16.7 | 15.6 | 15.9 | 10.2 | 17.5 | 28.3 | 18.8 | 16.3 | 13.6 |
| Percent with diabetes[c] | 12.2 | 11.0 | 10.7 | 9.2 | 15.9 | 13.5 | 11.9 | 11.3 | 10.8 |
| Percent with heart disease[c] | 3.5 | 4.3 | 4.4 | 0.6 | 2.7 | 1.6 | 4.5 | 4.1 | 4.3 |
| HIV rate[d] | 193.3 | NC | 162.1 | 597.1 | 167.6 | 53.7** | 434.0 | 186.5 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 64.9 | 63.4 | 64.7 | 65.3 | 61.0 | 64.0 | 59.6 | 64.0 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 61.7 | 64.7 | 64.5 | 68.8 | 56.3 | 69.1 | 59.6 | 63.5 | 66.5 |
| Percent received flu vaccine[c] | 38.4 | 42.0 | 40.7 | 37.0 | 44.6 | 42.4 | 35.0 | 40.8 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

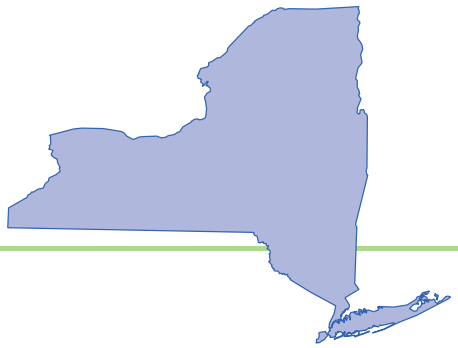
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 53.7 per 100,000 population (14 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 87.6 per 100,000 population (1 case).

# New York



## Introduction to New York's Health Equity Activities

New York had an estimated 2016 population of 19,746,000. Hispanics/Latinos (19 percent) are the largest racial-ethnic minority population, followed by Blacks/African Americans (16 percent), Asian Americans and NHOPI (9 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 12 percent of the population.[1] Approximately 5,822,000 New York residents live within a primary care health professional shortage area.[2]

In 1992, legislation created the Office of Minority Health and Health Disparities Prevention (OMH-HDP) within the New York State Department of Health (NYSDOH).[3] The OMH-HDP became operational in 1994. The NYSDOH's mission is to "protect, improve and promote the health, productivity and well-being of all New Yorkers."[4]

### New York Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Minority Health and Health Disparities Prevention |
| Strategic plan in place to address minority health or health equity | The Office of Minority Health and Health Disparities Prevention has a strategic plan that addresses minority health, health disparities, and health equity. The New York State Department of Health's strategic plan also includes approaches to reducing health disparities. |
| Date strategic plan was last updated | 2016. |
| Assessment plan in place to measure progress toward reducing health disparities | The New York State Department of Health has a department-wide performance plan with annual goals, objectives, and measures on a range of issues, including several that are related to minority health, health disparities, and health equity. |
| Key strategies used to achieve health equity | • Use data on racial and ethnic populations in program planning, implementation, and evaluation.<br>• Promote enhanced National Standards for Culturally and Linguistically Appropriate Services; work with partners to develop a curriculum for NYSDOH and state agency employees.<br>• Establish a community engagement model. |

## Organizational Structure

The 1992 legislative mandate creating the OMH-HDP also established the 14-member Minority Health Council, which serves as an advisory committee and provides recommendations to the NYSDOH Commissioner. The OMH-HDP provides administrative support to the Minority Health Council, such as coordinating meetings, taking minutes, and guiding recommendations and reports through the NYSDOH to the Commissioner. One OMH-HDP staff member acts as liaison between the NYSDOH and the Minority Health Council.

Included among the OMH-HDP's six full-time dedicated staff members are the director, deputy director, state partnership director, First Nations health and wellness program director, director of administrative services, and an executive assistant. In addition, the National CLAS Standards coordinator is employed half time and a state partnership secretary devotes 75 percent time to the OMH-HDP. Minority Health Council members are volunteers. The OMH-HDP does not expect staff allocations to change.

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 New York Public Health Law (Title 2F, § 240.2).

4 New York Department of Health (Revised May 2012). Mission, Vision, Values - New York State Department of Health. Available at the New York State DOH website. Last accessed 03/15/2017.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The OMH-HDP is housed within the New York State Department of Health. |
| SMHE staffing (full-time equivalents) | 8 |
| Advisory committee or panel | Minority Health Council |

## Program Goals and Activities

Updated annually, the OMH-HDP strategic plan addresses minority health, health disparities, and health equity. The NYSDOH's strategic plan, publicly available on its website, includes approaches to reduce health disparities. The NYSDOH also has an annual performance plan that includes goals, objectives, and measures, with specific aspects related to minority health, health disparities, and health equity.

The OMH-HDP's agenda is based both on its legislative mandate and the evolving priorities of the NYSDOH which, in part, are based upon the State Health Improvement Plan (i.e., *Prevention Agenda for 2013–2018*) and other initiatives. The OMH-HDP's authorizing legislation directives include promoting, supporting, and conducting research; serving as a liaison to the New York State Minority Health Council; assisting medical schools and state agencies to develop comprehensive programs to increase health care workforce diversity; integrating and coordinating state health care grant and loan programs; promoting opportunities for strategic planning to improve health equity and health care services within minority health communities; and assessing the impact of programs, regulations, and policies on minority health services.[5] Additionally, the OMH-HDP engages nongovernmental stakeholders, such as health care consumers and service providers, through a community engagement model for decision-making.

The OMH-HDP employs several strategies to address health equity. For example, it provides data on racial and ethnic populations for use in program planning, implementation, and evaluation. The OMH-HDP also works across all NYSDOH programs, state agencies, and community-based organizations to incorporate health disparities reduction initiatives and health equity advancement into programs, agendas, and policies. It also participates in several communities of practice (CoP), such as the NYSDOH's health literacy CoP and its epidemiology and biostatistician CoP, to address issues related to minority health. Together with the NYSDOH and community partners, the OMH-HDP gathers and analyzes quantitative data, which it uses to conduct spatial analyses identifying concentrations of racial and ethnic minority populations (i.e., where those populations represent 40 percent or more of the population). These so-called Section 240 areas are geographic units smaller than counties or ZIP codes in which populations are at higher risk for health disparities.

After identifying Section 240 areas, the OMH-HDP collects qualitative data in these areas through "listening sessions" of local residents. Using this community engagement model, the OMH-HDP uses these listening sessions both to engage individuals around such topics as women's health, men's health, prenatal care, homelessness, disability status, and LGBTQ status and to assess residents' access to care. The OMH-HDP has expanded this community engagement model to Section 240 areas in Brooklyn, where it uses qualitative and quantitative data for each Section 240 area to develop area-specific reports. In collaboration with the United Way, the OMH-HDP is conducting listening session in additional Section 240 areas. Moreover, the OMH-HDP is helping other offices in the NYSDOH expand use of this community engagement model, tailoring it to the needs and population of each office.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| New York State Department of Health | NYSDOH |
| Office of Minority Health and Health Disparities Prevention | OMH-HDP |

Another key strategy that the OMH-HDP employs relates to the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). For example, it reviews application and proposal requests to ensure that contractors promote and adhere to the National CLAS Standards. In doing so, and in partnership with the New York State Office of Public Health, the OMH-HDP is implementing an organizational cultural competency assessment of compliance with the National CLAS Standards, which helps extend the National CLAS Standards' reach to all of New York's health and human service agencies.

5 New York Public Health Law (Title 2F, § 240.2).

### Partnerships

| | |
|---|---|
| Primary collaborators | • New York State Office of Public Health<br>• New York State Minority Health Council<br>• United Way<br>• Native American Community Services of Erie and Niagara Counties<br>• St. Regis Mohawk Tribe<br>• Arthur Ashe Institute for Urban Health<br>• Northwell Health |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

The OMH-HDP works with the NYSDOH, state agencies, and community-based organizations to address a range of goals. For example, as part of its strategy to incorporate health disparities reduction initiatives and health equity advancement across programs, the OMH-HDP works with state agencies and community-based organizations through an interagency task force to establish National CLAS Standards guidelines. The OMH-HDP also works interdepartmentally within the NYSDOH and the epidemiology and biostatisticians community of practice through an Affirmative Action Advisory Committee. This committee launched a health equity campaign, *Unnatural Causes*, which uses quantitative data to identify the root causes of health disparities and develop appropriate programming. The NYSDOH uses *Unnatural Causes* in its training activities.

As noted above, the OMH-HDP works within the New York State Office of Public Health to implement an organizational cultural competency assessment that evaluates compliance with the National CLAS Standards. At the time of data collection, a steering committee was developing recommendations for best practices, based on the findings of a pilot assessment, to be replicated across the NYSDOH.

The New York State Office of Minority Health and Health Disparities Prevention completed the pilot, has relayed its findings to the NYS DOH participants involved in the pilot assessment, and the report of recommendations for replication is being drafted. In addition, a National CLAS Standards curriculum is in development and a compendium of resources and trainings has been drafted. These will be utilized towards a cultural competency training compendium for use by state agencies, state employees, and community partners who provide direct services.

For the aforementioned spatial analysis work to identify Section 240 areas, the OMH-HDP collaborates with the United Way through a formal contractual relationship. After engaging Brooklyn Section 240 areas to develop individualized area reports, the OMH-HDP teamed with the United Way to conduct listening sessions in other Section 240 areas. The United Way, which collects qualitative data and drafts reports on surveyed communities, will also help the OMH-HDP develop a tool kit to guide others in implementing the community engagement model.

Other partners work to address needs of particular racial and ethnic minority groups. For instance, the OMH-HDP has a formal contract with Native American Community Services of Erie and Niagara Counties to implement a First Nations Health and Wellness Initiative. The goal of this contract is to engage all First Nations across New York in setting priorities for community health outcomes. The OMH-HDP also has formally joined with the St. Regis Mohawk Tribe to establish a drop-in center that provides additional services to individuals who had received treatment in a detoxification program. Following a 1-year pilot project, based on community input and site visits, the OMH-HDP established a 5-year contract for the drop-in center to serve as a resource for the community.

The OMH-HDP also collaborates with the Arthur Ashe Institute for Urban Health to increase minority representation in medical and other health care professions by exposing young minority students to health sciences. Through the Mentorship in Medicine and Other Health Professions, the OMH-HDP has supported the expansion of the existing Health Sciences Academy (HSA) to include a Bridge Program that engages middle school students. The Bridge Program, which was piloted through this collaborative, is now an integral part of the HSA.

Since 2016, OMH-HDP utilizes its Mentorship in Medicine and Other Health Professions initiative to expand the existing HSA coursework to include a college preparatory curriculum and other professional skill building (e.g., resume writing, interview skills) opportunities for students.

New York State's largest health care provider, Northwell Health, has an informal relationship with the OMH-HDP. When Northwell conducted a feasibility study to inform changes to its health care system structure, it worked

with the OMH-HDP to conduct hospital-based and community-based listening sessions with community partners, employers, health care consumers, and other stakeholders. The OMH-HDP also conducted surveys, town hall meetings, and caucuses that informed the study.

The state also benefits from federal assistance. For example, the U.S. Office of Minority Health awarded a State Partnership Initiative to Address Health Disparities (SPI) grant aimed at improving health insurance enrollment, access to care, and health outcomes in Newburgh. To support this initiative, the OMH-HPD will produce a health profile based on local socioeconomic, health status, and health care utilization data. The OMH-HDP also will design and implement a culturally and linguistically tailored, evidence-based intervention to encourage Newburgh residents to obtain health insurance coverage.

The OMH-HDP also has a contractual relationship with the State University of New York at Albany to support a student intern who performs work for the OMH-HDP and university faculty

## Funding

| | |
|---|---|
| Annual budget (FY 2016–2017) of state/territorial minority health entity (SMHE) across all income sources | $779,200 |
| Annual budget (FY 2016-2017) of SMHE from state/territorial government | $579,200 |
| Largest funding source | State government |
| Anticipated changes to budget | Unknown |

The total FY 2016–2017 funding for the OMH-HDP was $779,200. In FY 2016–2017, the OMH-HDP had two key sources of funding: the State of New York ($579,200) and the U.S. Office of Minority Health (a $200,000 State Partnership Initiative to Address Health Disparities grant). The OMH-HDP provides resources to nongovernmental entities, including the State University of New York at Albany, the United Way, Native American Community Services of Erie and Niagara Counties, St. Regis Mohawk Tribe, and the Arthur Ashe Institute for Urban Health. The OMH-HDP does not expect funding to change in the next 2 years.

# New York

## New York Data

| Total Population[a]: 19,746,289 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 19.0 | 81.0 | 63.5 | 15.7 | 0.4 | 8.5 | 12.0 | 100.0 | NA |
| Percent of population medically uninsured[a] | 11.6 | 4.9 | 4.5 | 7.1 | 11.2 | 8.2 | 12.2 | 6.1 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 4.3 | 4.7 | 3.8 | 8.5 | SP | 3.3 | NC | 4.6 | 5.9 |
| Age-adjusted mortality rate[b] | 488.3 | 650.4 | 667.0 | 641.1 | 170.4 | 348.4 | NC | 640.7 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 14.9 | 13.6 | 13.9 | 15.4 | 13.0 | 10.2 | 22.8 | 13.9 | 13.6 |
| Percent with diabetes[c] | 11.6 | 10.0 | 9.0 | 13.7 | 10.7 | 10.8 | 15.8 | 10.2 | 10.8 |
| Percent with heart disease[c] | 3.3 | 4.3 | 4.6 | 2.7 | 4.5 | 2.6 | 5.4 | 4.1 | 4.3 |
| HIV rate[d] | 1731.1 | NC | 222.0 | 1908.8 | 122.1 | 110.5** | 3576.5 | 768.8 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 74.4 | 75.8 | 73.3 | 82.1 | 75.5 | 79.9 | 74.6 | 75.5 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 61.6 | 71.1 | 71.4 | 65.1 | 61.8 | 71.9 | 66.8 | 70.1 | 66.5 |
| Percent received flu vaccine[c] | 35.7 | 40.8 | 41.0 | 35.2 | 31.6 | 45.6 | 33.5 | 40.2 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

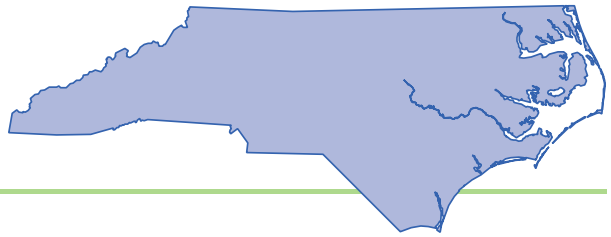
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 110.5 per 100,000 population (1,584 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 224.8 per 100,000 population (16 cases).

# North Carolina



## Introduction to North Carolina's Health Equity Activities

North Carolina had an estimated 2016 population of 10,147,000. Blacks/African Americans are the largest racial-ethnic minority population (22 percent), followed by Hispanics/Latinos (9 percent), Asian Americans and NHOPI (3 percent), and American Indians/Alaska Natives (1 percent). Persons self-identifying as multiracial or "other race" comprise 6 percent of the population.[1] Approximately 1,903,000 North Carolina residents live within a primary care health professional shortage area.[2]

In 1992, the North Carolina General Assembly established the Office of Minority Health and the Minority Health Advisory Council with public law HB1340, Part 24, Sections 165-166.[3] The mission of the office, whose name changed to the Office of Minority Health and Health Disparities (OMHHD) in 2001, is to "promote and advocate for the elimination of health disparities among all racial and ethnic minorities and other underserved populations in North Carolina."[4]

### North Carolina Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Minority Health and Health Disparities |
| Strategic plan in place to address minority health or health equity | The Office of Minority Health and Health Disparities is updating an existing strategic plan. |
| Date strategic plan was last updated | 2012 |
| Assessment plan in place to measure progress toward reducing health disparities | There are plans to include measureable outcomes within the updated strategic plan. |
| Key strategies used to achieve health equity | • Implementing the Minority Diabetes Prevention Program<br>• Organizing Health Equity "Lunch and Learn" events<br>• Promoting adoption and implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards)<br>• Restructuring the Community Health Ambassadors Program |

## Organizational Structure

The OMHHD is located within the North Carolina Department of Health and Human Services (DHHS). Four full-time, salaried staff members work in the OMHHD, including the executive director, two program staff, and one administrative staff member. Additionally, the OMHHD regularly hires temporary employees. In March 2017, three part-time temporary employees and one full-time temporary employee, as well as two university student interns, were staffing the OMHHD.

In 1992, the North Carolina General Assembly created the 15-member Minority Health Advisory Council with a mandate to serve racial and ethnic minority communities. Comprised of legislators, health care and human services professionals, and community leaders, its mission is to "promote and advocate for the elimination of health disparities among all racial/ethnic

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.
3 General Assembly of North Carolina. Public Law HB 1340, Part 24, Sections 165-166.
4 North Carolina Health and Human Services, Office of Minority Health and Health Disparities. About Us. Available at the OMHHD's website. Last accessed 5/8/17.

minorities and other underserved populations in North Carolina." In addition to reviewing strategies, programs, laws, and regulations to ensure that health equity is adequately addressed, the Minority Health Advisory Council advises and makes policy recommendations to the governor and DHHS Secretary.[5]

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Office of Minority Health and Health Disparities is located within the North Carolina Department of Health and Human Services |
| SMHE staffing (full-time equivalents) | 4 |
| Advisory committee or panel | Minority Health Advisory Council |

## Program Goals and Activities

With input from the Minority Health Advisory Council, the OMHHD is working to revise an existing strategic plan that was last updated in 2011–2012. The plan, which serves as an internal resource document and is not publicly available, does not currently include efforts to monitor progress toward reducing health disparities. However, the OMHHD anticipates that it will incorporate explicit measureable outcomes and a strategy to assess disparity improvement into its forthcoming version.

Priorities set forth by public and private organizations (e.g., U.S. Office of Minority Health, Association of State and Territorial Health Officials, National Partnership for Action to End Health Disparities, Regional Health Equity Councils, the University of North Carolina at Chapel Hill, and the North Carolina American Indian Health Board) inform the selection of OMHHD priorities. The OMHHD Director co-chairs the Social Determinants of Health Committee of the Region 4 Health Equity Council, which provides the OMHHD an opportunity to align its efforts with regional and national priorities.

The OMHHD is working to eliminate health disparities and achieve health equity through several strategies. The North Carolina Minority Diabetes Prevention Program, administered by the OMHHD in partnership with the Chronic Disease and Injury Section of the Division of Public Health, aims to increase participation in diabetes prevention programs among minority populations in North Carolina. Program components include outreach and marketing in minority communities, community prediabetes screenings, and lifestyle classes following Centers for Disease Control and Prevention curricula. The OMHHD has agreements with community partners and local health departments to implement program activities throughout most of the state.

Education is another key OMHHD strategy to carry out its mission. Within the DHHS, the OMHHD leads Health Equity Lunch and Learn events—quarterly sessions that are open to the public and foster dialogue on health equity issues. These events feature invited speakers and may include other activities, such as viewing a relevant documentary film. Moreover, the OMHHD works with the DHHS Women, Infants and Children (WIC) Program and other DHHS groups to conduct health equity trainings. It also encourages staff to participate in trainings developed by the North Carolina-based Racial Equity Institute.

Other key activities of the OMHHD include promoting adoption and implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) and training community members to be health ambassadors in minority communities. To support efforts around disseminating and adopting the National CLAS Standards, OMHHD staff provide trainings to local health departments. The Community Health Ambassadors Program is an educational program in North Carolina that aligns with the state's community health workers initiative. Its purpose is to train community members to be health ambassadors within minority and underserved communities. When the OMHHD initiated the program, it focused solely on diabetes, but the OMHHD has revamped the program to focus on health disparities more broadly.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Office of Minority Health and Health Disparities | OMHHD |
| Department of Health and Human Services | DHHS |

5 North Carolina Health and Human Services, Office of Minority Health and Health Disparities. Minority Health Advisory Council (MHAC). Available on the OMHHD website. Last accessed 5/11/17.

### Partnerships

| | |
|---|---|
| Primary collaborators | • North Carolina DHHS<br>• Division of Public Health: Women and Children Health Section, Chronic Disease and Injury Section, Oral Health Section, Environmental Health Section, Epidemiology Section<br>• Local health departments<br>• North Carolina American Indian Health Board<br>• North Carolina Health Professions Diversity<br>• North Carolina Colorectal Cancer Roundtable<br>• American Heart Association Mid-Atlantic Affiliate<br>• North Carolina Oral Health Collaborative<br>• Population Health Improvement Partners<br>• 50 Hoops, African Americans in Clinical Trials<br>• CareShare Health Alliance<br>• Duke Raleigh Hospital |
| Contracts or memoranda of understanding with any partners | Yes, contracts are implemented for some partnerships. |

The OMHHD works closely with the DHHS divisions and offices including the Division of Public Health and the North Carolina Office of Rural Health. For example, the Collaborative Improvement and Innovation Network, which aims to reduce infant mortality, is a key activity of the OMHHD partnership with the Division's WIC Program. The OMHHD also teams with the Division's Chronic Disease and Injury Section on initiatives, such as the Minority Diabetes Prevention Program, and is a partner in the Health Equity Learning Community. In addition, the OMHHD collaborates with the Division's Cancer Prevention and Control Branch and the Tobacco Prevention and Control Branch on community outreach efforts and education around health equity.

Through its partnership with the North Carolina American Indian Health Board, the OMHHD disseminates information on minority health issues that respond to the needs of the state's American Indian population. As updated minority health data in North Carolina become available, the OMHHD and the American Indian Health Board collaborate to update minority health fact sheets, as well as the 2010 *Racial and Ethnic Health Disparities in North Carolina Report Card*, available on the DHHS website.

## Funding

Funding in FY 2015 included federal allocations through a State Partnership Initiative to Address Health Disparities (SPI) grant from the U.S. Office of Minority Health; however, that funding ceased in 2015. In FY 2015, the OMHHD provided funding to 12 organizations that were participating in the Community Focused Eliminating Health Disparities Initiative. Additionally, in FY 2015, the OMHHD was a sponsor of the North Carolina Health Professions Diversity Conference. The OMHHD anticipates changes to future funding, and plans to seek supplemental funding opportunities to support ongoing operations.

# North Carolina

## North Carolina State Data

| Total Population[a]: 10,146,788 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 9.2 | 90.8 | 68.9 | 21.6 | 1.2 | 2.8 | 5.6 | 100.0 | NA |
| Percent of population medically uninsured[a] | 28.9 | 8.6 | 9.2 | 11.2 | 20.4 | 10.2 | 22.0 | 10.5 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 4.7 | 7.8 | 5.8 | 11.6 | SP | 6.0 | NC | 7.4 | 5.9 |
| Age-adjusted mortality rate[b] | 341.4 | 795.0 | 763.6 | 886.8 | 749.0 | 378.3 | NC | 782.4 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 7.9 | 12.8 | 11.8 | 14.9 | 16.5 | 8.3 | 11.0 | 12.4 | 13.6 |
| Percent with diabetes[c] | 7.1 | 11.7 | 10.5 | 14.7 | 13.1 | 7.5 | 9.9 | 11.3 | 10.8 |
| Percent with heart disease[c] | 2.6 | 5.0 | 5.4 | 3.8 | 4.2 | 0.6 | 1.5 | 4.7 | 4.3 |
| HIV rate[d] | 360.4 | NC | 134.9 | 1045.7 | 188.8 | 67.2** | 996.3 | 354.9 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 62.5 | 76.3 | 75.4 | 79.3 | 68.5 | 61.1 | 66.3 | 75.5 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 53.3 | 65.0 | 67.6 | 55.3 | 53.5 | 69.7 | 50.4 | 64.2 | 66.5 |
| Percent received flu vaccine[c] | 34.4 | 45.1 | 47.6 | 36.3 | 27.1 | 48.7 | 31.2 | 44.3 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

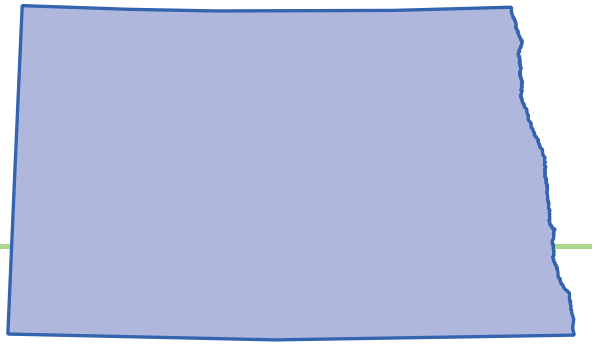
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 67.2 per 100,000 population (149 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 199.0 per 100,000 population (10 cases).

# North Dakota



## Introduction to North Dakota's Health Equity Activities

North Dakota had an estimated 2016 population of 758,000. American Indians/Alaska Natives are the largest racial-ethnic minority population (6 percent), followed by Hispanics/Latinos (3 percent), Blacks/African Americans (3 percent), and Asian Americans and NHOPI (1 percent). Persons self-identifying as multiracial or "other race" comprise 4 percent of the population.[1] Approximately 197,000 North Dakota residents live within a primary care health professional shortage area.[2]

Health equity activities in North Dakota are coordinated by the Office of Public Health Systems and Performance (OPHSP), which is housed within the North Dakota Department of Health (DOH) and reports to the state and deputy state health officer. In July 2016, oversight for special populations moved to the OPHSP from the former DOH Office of Special Populations. The OPHSP focuses on community health assessments, strategic plans, and quality improvement, and "works through collaboration and partnership to build capacity, improve performance and strengthen North Dakota's public health system."[3] A statewide Health Equity Committee was established to guide the OPHSP on minority health, health disparities, and health equity efforts.

### North Dakota Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | The Office of Public Health Systems and Performance coordinates minority health activities. |
| Strategic plan in place to address minority health or health equity | No standalone plan for minority health; the State Health Improvement Plan addresses health disparities strategies. |
| Date strategic plan was last updated | N/A |
| Assessment plan in place to measure progress toward reducing health disparities | The Health Equity Committee is working to incorporate health disparities assessment data collection into the maternal and child health program's 5-year needs assessment. |
| Key strategies used to achieve health equity | • Chaplaincy program to address mental health shortages<br>• Social media outreach targeted to American Indians<br>• All-hazards tribal consultation<br>• Assistance to individuals with HIV or other STDs<br>• Suicide prevention efforts in the lesbian, gay, bisexual, transgender, and queer/questioning (LGBTQ+) population; the American Indian population; and the older adult population<br>• Pregnancy Risk Assessment Monitoring System (PRAMS) to collect, analyze, and translate data from new mothers on health risk behaviors prior to, during, and immediately after pregnancy |

## Program Goals and Activities

Efforts to address health disparities are incorporated into strategic plans across the DOH. The State Health Improvement Plan includes measurable objectives to address health disparities in North Dakota. Several health issue-specific plans, such as the state plans for suicide, diabetes, maternal and child health, HIV and viral hepatitis, and cancer prevention, largely focus on health disparities and special populations. Additionally, the DOH Health Equity Committee has elected to adopt the

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 Public Health Systems and Performance, North Dakota Department of Health. Available on the DOH website. Last accessed 5/24/2017.

# North Dakota

National Stakeholder Strategy for Achieving Health Equity goals, established by the U.S. Office of Minority Health, and is also identifying strategies relevant to the DOH and its stakeholders.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| North Dakota Department of Health | DOH |
| Office of Public Health Systems and Performance | OPHSP |
| North Dakota State University | NDSU |

The Health Equity Committee is currently conducting a strategic planning process that will inform it's priorities. Initial work included categorizing and prioritizing health inequity factors. To strategize and prioritize going forward, the committee plans to create a health disparities profile; it also identified the need to coordinate efforts across the Department.

With this need in mind, the OPHSP is committed to increasing statewide collaboration on health disparities issues. For example, it is working to coordinate health disparities assessment data collection with the maternal and child health grant program's 5-year needs assessment. By broadening the initial needs assessment, the state will be able to identify health factors related to additional population health disparities.

As American Indians are the largest minority population, the OPHSP works closely with the North Dakota Indian Affairs Commission and the newly established American Indian Public Health Resource Center in the North Dakota State University to identify tribal health priorities. The state includes four American Indian reservations, each containing several tribes, and the OPHSP targets this constituency through several efforts. For example, the OPSHP leads a community chaplaincy program that serves tribal areas with mental health shortages, and will be working to recruit and train community health representatives from the reservations in suicide prevention and in addressing other mental health issues. The trained chaplains are being integrated into the Critical Incident Stress Management volunteer referral system for deployment and improved utilization by community members and emergency responders. Specifically, volunteers conduct group debriefings after critical incidents or emergencies (e.g., shootings), and the community chaplains provide resources, such as individual risk assessments for those in need of mental health services.

The OPHSP also led a tribal consultation session on hazardous event response with tribal leaders from all four reservations to develop consensus on how the DOH could best communicate with and respond to a hazardous event or crisis affecting tribal communities. The DOH's Indian Health Board representative facilitated the session, which yielded strategies that have since been put into place—such as an Indian Affairs Commission effort to develop a customized memorandum of understanding with each individual tribe.

Although minority health activities are largely coordinated by the OPHSP, other units within the DOH lead several specific minority health efforts. For example, the Tobacco Prevention and Control Program of the Division of Chronic Disease, the Division of Cancer Prevention and Control, the Division of Nutrition and Physical Activity, and the Division of Family Health conduct social media campaigns with culturally appropriate messaging targeted to the American Indian population. Additionally, the Division of Injury Prevention and Control works with health care systems to adopt a zero suicide policy, providing technical assistance and resources for suicide prevention education that target at-risk populations (i.e., lesbian, gay, bisexual, transgender, and queer/questioning populations; American Indian communities; and older adults).

The DOH Division of Disease Control strives to make populations across North Dakota aware of resources and services related to HIV and other sexually transmitted disease. The division works with local public health departments to increase availability and awareness of such services. The Ryan White Part B program supports core medical and support services to people at or below 400 percent of the federal poverty level who are living with HIV. Services include health insurance premium assistance, AIDS drug assistance, housing, and transportation, among others.

Finally, the DOH Community Health Section facilitated "Health in All Policies" training to partners across North Dakota that addressed strategies for addressing health inequities across all health department work.

### Partnerships

| | |
|---|---|
| Primary collaborators | • North Dakota Indian Affairs Commission<br>• Lutheran Social Services of North Dakota<br>• North Dakota State University's American Indian Public Health Resource Center<br>• Local public health agencies<br>• North Dakota Medicaid |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

Governmental and nongovernmental organizations partner in various ways with the OPHSP to eliminate health disparities and advance health equity. Through an informal partnership, the North Dakota Indian Affair Commission's Indian Health Systems Administrator advises the DOH and other agencies on tribal health issues. The administrator also serves on the DOH Health Equity Committee, representing the American Indian population of North Dakota.

Lutheran Social Services of North Dakota, a nonprofit refugee resettlement organization, partners with the DOH through its formal contract with the state's Department of Human Services. It also collaborates with the DOH to increase awareness and access to health services for HIV and other STDs.

To increase access to health services, the OPHSP and the Maternal and Child Health Grant Program formally contracts with North Dakota State University, partnering with its newly established American Indian Public Health Resource Center. Together, they collaborate on such efforts as data collection, relationship building, and providing technical assistance to the tribes. The DOH looks to the center for expertise on culturally appropriate strategy implementation, best practices, and assistance in training health department staff. The contract specifies that the center will assist with assessment activities related to health inequities and health disparities.

Several contracts are also in place with local public health government agencies, including those that provide direct patient care, to incorporate health disparity reduction goals into their work. The DOH is planning to identify population health metrics, including some measures of health equity, with these local agencies.

Finally, it informally partners with North Dakota Medicaid to address health disparities in vulnerable and underserved populations across the state.

## Organizational Structure

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The OPHSP is housed within the North Dakota DOH |
| SMHE staffing (full-time equivalents) | 0.45 |
| Advisory committee or panel | Healthy North Dakota Health Disparities Committee |

After the director of the former DOH Special Populations Section retired in 2016, health equity work moved into the OPHSP, which primarily works on system development, collaboration, and coordination across the health department.

The OPHSP director dedicates about 15 percent of her time to coordinating internal minority health and health equity initiatives, facilitating the Health Disparities Committee, and reaching out to partners. Beyond this position, the DOH staff members of the Health Equity Committee each dedicates approximately 5 percent of time to minority health and health equity initiatives.

A large portion of health equity efforts are contracted to North Dakota State University. The principal investigator on this contract spends about 30 percent time on DOH minority health and health equity activities. A university consultant and a student intern each spend 10 percent of their time on DOH-contracted health equity initiatives.

At the time of data collection, staffing changes were being anticipated over the next 2 years, because the OPHSP only began reestablishing the program and contracting efforts to outside agencies in 2016.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $80,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $80,000 |
| Largest funding source | State government |
| Anticipated changes to budget | None |

Total FY 2015 funding for DOH minority health activities was $80,000. In FY 2015, this supported the director of the former Special Populations Section. Funding has since been reallocated into contracts overseen by the OPHSP.

The OPHSP provided funding to external partners, entities for health disparities, and health equity activities. The American Indian Public Health Resource Center receives funding to assist with tribal data collection and relationship building. North Dakota State University receives funding to assist the DOH on coordinating health equity activities.

DOH will be hiring a position dedicated to addressing statewide health disparities being supported through various grant funds.

# North Dakota

## North Dakota State Data

| Total Population[a]: 757,953 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 3.2 | 96.8 | 86.8 | 2.6 | 6.1 | 0.9 | 3.6 | 100.0 | NA |
| Percent of population medically uninsured[a] | 27.1 | 7.5 | 5.9 | 27.4 | 29.2 | 1.2 | 12.4 | 8.1 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 7.3 | 5.9 | SP | SP | SP | NC | 7.2 | 5.9 |
| Age-adjusted mortality rate[b] | 377.9 | 689.8 | 661.3 | 375.1 | 1440.7 | 429.0 | NC | 688.4 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 17.7 | 12.8 | 12.3 | 10.8 | 15.6 | 10.5 | 31.2 | 12.8 | 13.6 |
| Percent with diabetes[c] | 7.3 | 8.7 | 8.4 | 10.0 | 15.1 | 4.4 | 4.9 | 8.6 | 10.8 |
| Percent with heart disease[c] | 7.2 | 4.1 | 4.0 | 3.8 | 5.2 | 0.0 | 8.9 | 4.1 | 4.3 |
| HIV rate[d] | 109.6 | NC | 32.9 | 752.6 | 39.1 | 33.9** | 153.6 | 53.4 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 49.2 | 62.7 | 63.1 | 63.8 | 61.1 | 57.9 | 46.7 | 62.6 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 42.4 | 66.9 | 68.6 | 51.8 | 42.5 | 45.7 | 55.1 | 66.5 | 66.5 |
| Percent received flu vaccine[c] | 32.5 | 42.2 | 42.0 | 46.7 | 44.5 | 51.7 | 32.2 | 42.1 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 33.9 per 100,000 population (3 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 0.0 per 100,000 population (0 cases).

# Northern Mariana Islands

## Introduction to Northern Mariana Islands' Health Equity Activities

The Northern Mariana Islands had an estimated 2010 population of 54,000. Asian/Pacific Islanders are the largest racial-ethnic minority population (85 percent). Persons self-identifying as multiracial or "other race" comprise 13 percent of the population.[1]

To improve the coordination of health care delivery, the governor signed in January 2009 the Commonwealth Healthcare Corporation (CHCC)—Public Law 16-51. As a public corporation, the CHCC serves as the Commonwealth of the Northern Mariana Islands (CNMI) hub for public health and health care services. The CHCC's mission, "improving CNMI health and well-being through excellence and innovation in service," is aligned with its vision, which is to "improve the quality of life for the CNMI community through its innovative preventive/urgent care services."[2] With most of the population belonging to a racial minority group, health equity activities are part of the CHCC's routine operations.

### Northern Mariana Islands Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Commonwealth Healthcare Corporation, Division of Public Health Services |
| Strategic plan in place to address minority health or health equity | The *Commonwealth Healthcare Corporation Strategic Plan* is updated periodically. |
| Date strategic plan was last updated | 2014 |
| Assessment plan in place to measure progress toward reducing health disparities | No |
| Key strategies used to achieve health equity | • Strengthening collaboration between public health and medical sectors<br>• Campaigning for Medicaid Equity<br>• Implementing sliding fee scale for medically uninsured<br>• Improving access to healthy food options<br>• Reinforcing smoke-free laws |

## Organizational Structure

Following Public Law 16-51, the CHCC formed in 2009 as a public corporation with substantial autonomy within the territorial government. The CHCC has responsibility for a wide range of health care endeavors—from public health activities to clinic- and hospital-based care delivery. Its chief executive officer oversees daily operations of the CHCC and ensures compliance with government regulations. In January 2017, the governor signed into law measures that called for the creation of a governing board for the CHCC.[3]

Altogether, the CHCC has approximately 500 staff members, with most employees spending at least some portion of their workday addressing minority health or advancing health equity. Volunteers also support an array of CHCC activities and initiatives. Nursing students from the Northern Marianas College assist the CHCC with community outreach and health promotion activities.[4] The Medical Reserve Corps, which is comprised of approximately 165 volunteers (clinicians, public health profes-sionals, and community members), supports the

1 U.S. Census Bureau. 2010 Census Island Areas: 2010 Census Detailed Crosstabulations.

2 Commonwealth Healthcare Corporation (CHCC) Strategic Plan, 2015-2020. Available on the CHCC website. Last accessed 4/3/17.

3 Saipan Tribune. Board Gains Control of CHCC. (Jan 18, 2017). Available on the Saipan Tribune website. Last accessed 4/7/17.

4 Commonwealth of Northern Mariana Islands - Northern Marianas College. "Welcome to the Nursing Department." Available on the Northern Marianas College website. Last accessed 8/4/2017.

CHCC's Public Health and Hospital Emergency Preparedness Program.[5] These volunteers are trained to respond to public health and other emergencies in the CNMI.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The CHCC is largely independent from territorial government. |
| SMHE staffing (full-time equivalents) | The CHCC has approximately 500 employees, many of whom spend some time supporting population health initiatives. |
| Advisory committee or panel | The CHCC board of trustees serves in a governing role to the CHCC. |

## Program Goals and Activities

The *Commonwealth Healthcare Corporation Strategic Plan 2015-2020 ("CHCC Strategic Plan")* highlights six core strategies and related outcome goals for the years 2015–2020. Eight operational strategies will support the CHCC in achieving the stated goals.[6] An environmental scan; strengths, weaknesses, opportunities, and threats (SWOT) analysis; and an interim action plan helped inform the development of the draft CHCC Strategic Plan. The CHCC sought feedback from community members on the draft prior to finalizing the plan.[7]

The CHCC uses surveillance data to help identify health priorities. Its Health and Vital Statistics Office supports the CHCC in monitoring the health of the CNMI population. One of the office's core responsibilities is to identify problem areas, such as infant mortality, teen pregnancy, and non-communicable diseases. Per legislation passed in 2016, the CHCC is working to establish a medical claims and clinical data warehouse to support monitoring and evaluation activities and improve care delivery.[8]

One major focus of the CHCC has been on strengthening the collaboration between the CHCC's Division of Public Health Services, its Division of Hospital Services, and community clinics. Efforts have focused on sharing resources and personnel to expand reach and enhance quality of care. For example, the Division of Public Health Services recognized a need for public health dietetic services in the CNMI but lacked trained personnel, and therefore worked with the Division of Hospital Services to acquire the services of a hospital dietician.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Commonwealth of the Northern Mariana Islands | CNMI |
| Commonwealth Healthcare Corporation | CHCC |

Racial and Ethnic Approaches to Community Health (REACH), administered through the Centers for Disease Control and Prevention (CDC), is an initiative to reduce health disparities among racial and ethnic minority populations. The University of Hawaii receives CDC funding to support and implement REACH projects. Through a sub-award from the University of Hawaii, the CHCC's Non-Communicable Disease Bureau of the Division of Public Health Services is working to implement REACH projects in the CNMI. The primary goals of the CNMI REACH projects are to increase access to smoke-free and tobacco-free environments, and increase access to healthy food options.[9] To reach these goals, the Non-Communicable Disease Bureau is encouraging restaurants to offer healthy options[10] and reinforcing the CNMI "Smoke-Free Air Act of 2008" with community education and outreach.[11]

5 Hospital and Public Health Preparedness Program. Available on the Commonwealth Healthcare Corporation website. Last accessed 8/4/2017.

6 Commonwealth Healthcare Corporation (CHCC) Strategic Plan, 2015-2020. Available on the CHCC website. Last accessed 4/3/17.

7 Commonwealth Healthcare Corporation (CHCC) Strategic Plan, 2015-2020. Available on the CHCC website. Last accessed 4/3/17.

8 Saipan Tribune. Bill Establishing CHCC Claims, Clinical Data Warehouse Signed into Law (July 2016). Available on the Saipan Tribune website. Last accessed 8/4/2017.

9 CNMI R.E.A.C.H.: About R.E.A.C.H. (Racial and Ethnic Approaches to Community Health). Information about the R.E.A.C.H. program is available on both the REACHCNMI website and the CHCC Non-Communicable Disease Bureau's website. Last accessed 8/4/2017.

10 CNMI R.E.A.C.H. (Racial and Ethnic Approaches to Community Health) - Health Restaurant Project. Information is available on both the REACHCNMI website and the CHCC Non-Communicable Disease Bureau's website. Last accessed 8/4/2017.

11 CNMI R.E.A.C.H. (Racial and Ethnic Approaches to Community Health) – Smoke Free Air Act FAQ. Information is available on both the REACHCNMI website and the CHCC Non-Communicable Disease Bureau's website. Last accessed 8/4/2017.

### Partnerships

| | |
|---|---|
| Primary collaborators | • CNMI Public School System<br>• Commonwealth Cancer Association<br>• Commonwealth Diabetes Coalition<br>• Local churches<br>• CNMI Office of Homeland Security and Emergency Management<br>• CNMI Department of Fire and Emergency Medical Services |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

The CHCC partners with governmental and nongovernmental organizations to advance the health of the CNMI population. The CHCC works collaboratively with the CNMI Public School System to support data collection activities and public health community outreach activities. Students and staff from the CNMI Public School System work with the CHCC on various initiatives including teen pregnancy prevention and vaccination. The CHCC collaborates with the Commonwealth Cancer Association on cancer registry activities and provides trainings for their staff. Access to a certified diabetes educator is possible because of the partnership between the CHCC and the Hardt Eye Clinic and Diabetes Education Center. CHCC staff also work with local churches to disseminate diabetes education to church members.

The CNMI Office of Homeland Security and Emergency Management and the CNMI Department of Fire and Emergency Medical Services are also key partners for the CHCC. The CHCC shares resources and provides trainings with both entities to improve population health and access to care. Trainings focus on topics such as emergency response and infectious diseases. Moreover, a staff member from the CHCC serves as the medical director for the Department of Fire and Emergency Medical Services.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $56,793,610 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $2,000,000 for CHCC public health operations and activities |
| Largest funding source | Federal government |
| Anticipated changes to budget | Possible budget increase |

Of the CHCC's total FY 2015 budget, federal grants and programs were the primary source of funding (approximately $31,000,000) to support public health and health care service delivery. The remaining funding came from the organization's revenue, CNMI government, and other local sources. During this time, the CHCC provided funding to youth agencies for tobacco prevention activities, and to the Commonwealth Cancer Association to support services for people and families affected by cancer, as well as cancer survivors. The CHCC anticipates possible budget increases during 2017–2019, in response to changes in the CNMI economy.

# Northern Mariana Islands

## Northern Mariana Islands Territory Data

| Total Population[a]: 53,883 | Race | | | | | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Pacific Islander | | | Asian | | | | | | | |
| | Chamorro | Carolinian | Other PI | Filipino | Chinese | Korean | Other Asian | Multi-racial | Other | Territory Total | National Total |
| **Population Characteristics** | | | | | | | | | | | |
| Percent of state population[a] | 23.9 | 4.6 | 6.4 | 35.3 | 6.8 | 4.2 | 3.7 | 12.7 | 2.5 | 100.0 | NA |
| Percent of population medically uninsured[a] | 11.5 | 17.2 | 27.0 | 48.3 | 64.4 | 61.9 | 48.0 | 17.0 | 20.1 | 33.7 | 16.3[b] |
| **Health Disparities** | | | | | | | | | | | |
| Vital Statistics | | | | | | | | | | | |
| Infant mortality rate[c] | | | | | | | | | | SP | 5.9 |
| Age-adjusted mortality rate[d] | | | | | | | | | | 876.0 | 733.1 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | | | |
| Asthma[e] | | | | | | | | | | NC | 13.6 |
| Diabetes[e] | | | | | | | | | | NC | 10.8 |
| Heart Disease[e] | | | | | | | | | | NC | 4.3 |
| HIV[f] | | | | | | | | | | 14.9 | 362.3 |
| Preventive Services | | | | | | | | | | | |
| Routine check-up (past 12 months)[e] | | | | | | | | | | NC | 72.2 |
| Oral health visit (past 12 months)[e] | | | | | | | | | | NC | 66.5 |
| Flu Vaccine Received[e] | | | | | | | | | | NC | 38.4 |

**Note:** This jurisdiction's vital statistics, disease prevalence, and preventive services data are not available by race and ethnicity in the data sources compiled for this report.

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: U.S. Census Bureau. 2010 Census Island Areas: 2010 Census Detailed Crosstabulations.

b Source: U.S. Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States: 2010.

c Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

d Source: CDC National Vital Statistics Reports, Deaths: Final Data for 2015.

e Source: Behavioral Risk Factor Surveillance System, 2016.

f Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015.

# Ohio

## Introduction to Ohio's Health Equity Activities

Ohio had an estimated 2016 population of 11,614,000. Blacks/African Americans are the largest racial-ethnic minority population (13 percent), followed by Hispanics/Latinos (4 percent), Asian Americans and NHOPI (2 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 4 percent of the population.[1] Approximately 1,397,000 Ohio residents live within a primary care health professional shortage area.[2]

Health equity and access are highlighted as "core public health responsibilities" of the Ohio Department of Health (ODH).[3] Within the ODH, the Office of Health Equity (OHE) is the primary entity responsible for addressing minority health, health disparities, and health equity. The OHE's key function is to provide consultations to ODH programs to ensure that program activities address minority health and health disparities. In addition to the OHE, the Ohio Commission on Minority Health—an autonomous state agency outside of the ODH—focuses exclusively on minority health and health equity issues. Created in 1987 through Amended Substitute House Bill 171, the commission is "dedicated to eliminating disparities in minority health through innovative strategies and financial opportunities, public health promotion, legislative action, public policy and systems change."[4]

### Ohio Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Health Equity |
| Strategic plan in place to address minority health or health equity | The *Ohio 2017-2019 State Health Improvement Plan* has a strong focus on health equity; the *Ohio Department of Health: Strategic Plan 2015-2016* also highlighted health equity as a core pillar of public health. |
| Date strategic plan was last updated | The *Ohio 2017-2019 State Health Improvement Plan* was last updated in February 2017; the *Ohio Department of Health: Strategic Plan 2015-2016* was last updated in 2015. Strategic Plan will be updated in 2018. |
| Assessment plan in place to measure progress toward reducing health disparities | Outcome objectives and a plan for evaluation are included in the *Ohio 2017-2019 State Health Improvement Plan.* |
| Key strategies used to achieve health equity | • Identifying strategies in the State Health Improvement Plan likely to reduce disparities<br>• Implementing a comprehensive health equity policy<br>• Identifying local social determinants of health through market research and geographic information system technology<br>• Providing cultural competency trainings<br>• Supporting initiatives to reduce disparities in infant mortality and poor birth outcomes |

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.
3 Ohio Department of Health's 2015 Strategic Plan. Available on the ODH website. Last accessed 8/4/17.
4 "The Mission and Vision of the Ohio Commission on Minority Health." Available on the Ohio Commission on Minority Health's website. Last accessed 8/4/17.

## Organizational Structure

The OHE is housed within the Office of Health Policy and Performance Improvement of the ODH. In addition to its two state-supported full-time staff members (the director and assistant director of health equity), an Ohio State University grant supports a third full-time employee. The grant-funded staff member, a disabilities specialist, works with ODH programs to create strategies addressing health disparities among persons with disabilities. Other ODH staff who support health equity initiatives include the director of the Office of Health Policy and Improvement. Several staff from the the ODH's Bureau of Maternal and Child Health and Bureau of Health Promotion also work to eliminate health disparities through initiatives led by the Ohio Equity Institute and Creating Healthy Communities. The Ohio Commission on Minority Health also has several staff members devoted to reducing health disparities and achieving health equity.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Office of Health Equity is housed under the Office of Health Policy and Performance Improvement of the Ohio Department of Health |
| SMHE staffing (full-time equivalents) | 3 |
| Advisory committee or panel | None |

## Program Goals and Activities

The *Ohio Department of Health: Strategic Plan 2015-2016* outlines four goals and objectives: (i.e., aligning all ODH systems to fully support national and state priorities, ensuring effective decision-making processes, improving data infrastructure and usage, and workforce development). In 2016, the ODH conducted a state health assessment to better understand overall health of the state's population, which it used to inform priority issues for a statewide health improvement strategy. Together with a broad range of stakeholders that comprised a SHIP advisory committee, the ODH used the assessment results to develop the *2017-2019 Ohio State Health Improvement Plan (SHIP)*. Specifically, the 2017-2019 Ohio SHIP highlights three priority topics: mental health and addiction, chronic disease, and maternal and child health. For each, the advisory committee identified those populations experiencing the greatest disparities. In addition to targeted outcome indicators for tracking progress toward reaching state goals, each of the three priority topics have associated action plans that describe outcomes and target goals in more detail. The Office of Health Policy and Performance Improvement, which includes the OHE, is responsible for monitoring outcomes for each priority area and population. The OHE's role in the SHIP development process was to ensure that the plan addressed minority health and included strategies to reduce health disparities. As a result, the 2017-2019 SHIP identifies crosscutting factors influencing health outcomes. Compared with its predecessors, this SHIP also represents an increased focus on health equity and social determinants of health.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Ohio Department of Health | ODH |
| Office of Health Equity | OHE |

Strategies included in the 2017-2019 SHIP are intended to guide the direction of programs across the ODH, and the OHE consults with individual ODH programs to ensure that those programs adequately address needs of priority populations. The OHE provides health equity consultations for ODH solicitations and responses to external funding announcements.

Other OHE-led activities include the use of market research data and geographic information system (GIS) technology to identify local social determinants of health. The OHE maintains licensure to gather market research and GIS data, and educates ODH program staff and subgrant awardees on using this data in their decision-making processes. For example, using GIS data, the OHE worked with an Ohio community to identify neighborhoods for targeted prevention efforts. In addition, OHE staff provide cultural competency trainings to staff across the ODH. The OHE also is planning a cultural competency assessment with all ODH offices and bureaus and will use its results to help develop individualized action plans to ensure ODH-wide compliance with the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards).

In response to higher-than-average infant mortality rates, Ohio allocates resources to eliminating disparities and reducing infant mortality rates. The Ohio legislature in 2016 passed Senate Bill 332, which calls for specific

strategies (e.g., improved data collection) to eliminate disparities in infant mortality and poor birth outcomes. Additionally, through the ODH's Bureau of Maternal and Child Health's Ohio Institute for Equity in Health Outcomes program (also known as the Ohio Equity Institute), nine Ohio communities with high rates of infant mortality are partnering with the ODH to improve birth outcomes, particularly among African American women.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Ohio Commission on Minority Health<br>• Ohio Statewide Health Disparities Collaborative<br>• Ohio Collaborative to Prevent Infant Mortality<br>• Ohio State University, Kirwan Institute for the Study of Race and Ethnicity<br>• Local health departments and hospitals |
| Contracts or memoranda of understanding with any partners | Yes, contracts are implemented for some partnerships (e.g., those the Kirwan Institute for the Study of Race and Ethnicity). |

The OHE partners with several governmental and nongovernmental organizations to advance health equity in Ohio. For example, an OHE staff member serves on the Ohio Commission on Minority Health's advisory board. The Commission, whose focus areas include infant mortality, cancer, diabetes, cardiovascular disease, substance abuse, violence, and lupus, supports Ohio Equity Institute initiatives aimed at reducing disparities in infant mortality through funding of local activities.

Statewide coalitions also partner with the OHE to eliminate health disparities in Ohio. An OHE staff member is part of the Ohio Statewide Health Disparities Collaborative, which is working to improve race and ethnicity data collection. Another statewide coalition, the Ohio Collaborative to Prevent Infant Mortality, partners with the OHE to improve minority health and eliminate infant mortality disparities.

Ohio State University's Kirwan Institute for the Study of Race and Ethnicity collaborates with the OHE on health disparity mapping efforts. An OHE staff member works with the Kirwan Institute to develop heat maps that illustrate areas with large health disparities. Together, the OHE and the Kirwan Institute lead presentations about how to use health disparity data maps to make informed public health decisions. As noted above, an Ohio State University-funded staff member works full time in the OHE on issues related to persons with disabilities. A memorandum of understanding between Ohio State University and the ODH supports this work arrangement.

Local health departments and hospitals are key partners for the ODH as it pursues SHIP priorities. The ODH has asked local health departments and hospitals to implement at least one strategy for two of the three priority topics in the 2017-2019 SHIP.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $870,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $0 |
| Largest funding source | Federal Block Grant |
| Anticipated changes to budget | The ODH has requested additional state funding for infant mortality work. In the 2017–18 budget, the budget request was $4 million to support Ohio Equity Institute health equity project. |

The FY 2017 budget for the Ohio Equity Institute was $2,499,870 from the State of Ohio. In Creating Healthy Communities and other grant programs, the ODH provides resources to local communities and health departments to address priority topics and populations within particular communities. The Ohio Commission on Minority Health also provides resources to local organizations to implement strategies addressing the commission's focus areas.

# Ohio

## Ohio State Data

| Total Population[a]: 11,614,373 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 3.6 | 96.4 | 81.6 | 12.5 | 0.2 | 2.0 | 3.7 | 100.0 | NA |
| Percent of population medically uninsured[a] | 15.1 | 5.6 | 5.5 | 7.7 | 13.9 | 4.4 | 9.1 | 5.9 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 6.1 | 7.2 | 5.8 | 14.0 | SP | SP | NC | 7.2 | 5.9 |
| Age-adjusted mortality rate[b] | 448.4 | 838.4 | 824.0 | 952.8 | 293.1 | 393.7 | NC | 832.3 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 26.3 | 13.6 | 13.3 | 17.0 | 35.5 | 6.3 | 24.2 | 14.0 | 13.6 |
| Percent with diabetes[c] | 12.2 | 11.1 | 10.9 | 12.6 | 18.4 | 3.2 | 13.7 | 11.1 | 10.8 |
| Percent with heart disease[c] | 1.6 | 5.0 | 5.2 | 3.3 | 13.7 | 0.6 | 2.3 | 4.9 | 4.3 |
| HIV rate[d] | 422.0 | NC | 118.0 | 783.1 | 88.4 | 46.9** | 584.1 | 212.5 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 76.6 | 75.5 | 75.1 | 78.7 | 89.3 | 67.2 | 75.8 | 75.5 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 65.6 | 68.3 | 69.1 | 63.3 | 66.9 | 71.2 | 68.0 | 68.4 | 66.5 |
| Percent received flu vaccine[c] | 32.7 | 38.9 | 39.0 | 36.5 | 33.1 | 44.9 | 34.0 | 38.6 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

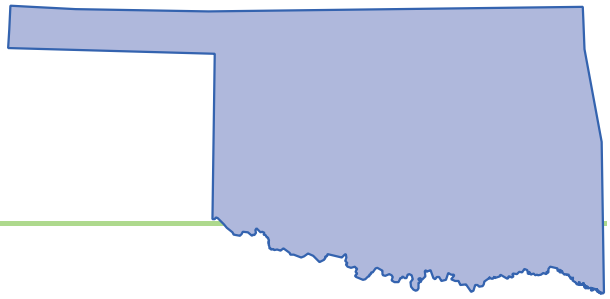
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 46.9 per 100,000 population (94 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 61.7 per 100,000 population (2 cases).

# Oklahoma



**Special Note:** The information in this profile is from FY 2014 and does not reflect the Oklahoma State Department of Health's (OSDH) current organizational structure or health equity strategies. On October 30, 2017, then Commissioner of Health and Senior Deputy Commissioner officially submitted their resignation to the Board of Health (BOH) effective immediately. Since that time, many additional separations among all levels of the organization have occurred. The Governor approved a critical infusion of state funds in the amount of $30 million to help stabilize the immediate financial situation; however, it did not solve all the issues facing the agency for the long term. The agency continues to perform a hard reset focusing solely on its core mission of public health in the most efficient and effective manner. Many additional actions have been and are being taken to shore up business operations and ensure the continuity and fiscal soundness of the OSDH. These initial actions include a reduction in force of nearly 200 employees; a reorganization of the agency's leadership; and plans for the development of a new financial reporting system. The OSDH continues to work to implement business processes and efficiencies to meet core public health services and to improve financial controls.

## Introduction to Oklahoma's Health Equity Activities

Oklahoma had an estimated 2016 population of 3,924,000. Hispanics/Latinos are the largest racial-ethnic minority population (10 percent), followed by American Indians/Alaska Natives (8 percent), Blacks/African Americans (7 percent), and Asian Americans and NHOPI (2 percent). Persons self-identifying as multiracial or "other race" comprise 11 percent of the population.[1] Notably, Oklahoma is home to 38 federally recognized tribal nations.[2] Approximately 1,312,000 Oklahoma residents live within a primary care health professional shortage area.[3]

### Oklahoma Minority Health Overview

| | |
|---|---|
| Name of state/territorial minority health entity | Oklahoma State Department of Health, Office of Minority Health |
| Strategic plan in place to address minority health or health equity | A strategic plan specifically to address minority health or health equity is not available. However, minority health and health equity are a part of the State Health Improvement Plan. |
| Date strategic plan was last updated | 2015 |
| Assessment plan in place to measure progress toward reducing health disparities | In development |
| Key strategies used to achieve health equity | • *A Healthy Baby Begins with You* baby showers<br>• *Body and Soul* physical fitness and nutrition program<br>• Community health chats<br>• Interpretation/translation services for populations with limited English proficiency<br>• Minority Health at a Glance |

1 American Community Survey Public Use Microdata, 2016.
2 Office of the Tribal Liaison Website. 2016. Available on the Oklahoma Department of Health website. Last accessed 6/16/2016.
3 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

# Oklahoma

In 1994, the Oklahoma Office of Minority Health (OOMH) was created by the Oklahoma State Board of Health, the body that governs the Oklahoma State Department of Health (OSDH).[4] The OOMH's mission is to "lead Oklahoma in improving the health status of Oklahoma's minority and underserved populations by partnering, developing policies and implementing strategies to reduce and ultimately eliminate health disparities."[5]

## Organizational Structure

The Oklahoma Partnerships for Health Improvement, formerly the Community Development Service within the OSDH, consists of the following divisions: Health Equity and Resource Opportunities (HERO), Health Promotion, Office of Minority Health, Office of Performance Management, and Office of Tribal Liaison.[6] It also houses "Turning Point," a conglomeration of 73 community partnerships working to "enhance the health status of Oklahomans."[7] The OOMH was established as the sole office responsible for addressing minority health issues in the State. Its central focus is to eliminate health disparities within the state. OOMH's sister divisions, the Office of the Tribal Liaison and HERO, are dedicated to addressing health equity and social determinants of health in Oklahoma. Due to the nature of minority health issues, there is considerable collaboration between the OOMH and these two other Partnership divisions.

Advising the OOMH is the Health Disparities Advisory Coalition, a working group comprised of individuals from a broad range of professional backgrounds and racial/ethnic groups. Coalition members represent, for example, the Clinton and Lawton Indian Hospital, the Latino Community Development Agency, health care professionals, and other community members. The Coalition disseminates health disparity information to the community, provides information about the status of minority health to the state, and advises on state efforts to ensure an adequate focus on disparity elimination.

OOMH's team of six full-time individuals who dedicate all efforts to minority health and health disparities elimination initiatives includes the OOMH director, a project coordinator, an outreach coordinator, two interpreters/translators, and an administrative assistant. The team also works closely with a full-time evaluator from the Community Epidemiology Department, who spends one-third of her time assisting the OOMH's minority health and health disparity work. This staffing allocation is not anticipated to change in the near future. Unpaid community volunteers help to implement OOMH projects and activities, especially the *A Healthy Baby Begins with You* baby showers. These volunteers are often college interns from the public health programs at Oklahoma University and the University of Central Oklahoma. In several instances, student interns have become full-time paid employees of the OSDH.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Oklahoma State Department of Health | OSDH |
| Oklahoma Office of Minority Health | OOMH |
| Oklahoma Health Equity Campaign | OHEC |
| Health Equity and Resource Opportunities | HERO |

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Office of Minority Health is housed within the Partnerships for Health Improvement division of the Oklahoma State Department of Health |
| SMHE staffing (full-time equivalents) | 6 |
| Advisory committee or panel | Health Disparities Coalition |

4 Oklahoma State Board of Health Website. 2016. Available on the Oklahoma Department of Health website. Last accessed 12/21/2017.
5 Oklahoma Office of Minority Health Website. 2016. Available on the Oklahoma Department of Health website. Last accessed 6/16/2016.
6 Partnerships for Health Improvement Website. 2016. Available on the Oklahoma Department of Health website. Last accessed 6/16/2016.
7 "Turning Point" grew out of a pilot effort originally funded by the Robert Wood Johnson and W.K. Kellogg Foundations in 1998. See the Oklahoma Turning Point Initiative Website. 2016. Available on the Oklahoma Department of Health website. Last accessed 6/16/2016.

## Program Goals and Activities

The OOMH is developing a strategic plan to address minority health and health equity. It is guided in this effort by Oklahoma's Health Improvement Plan. Health disparities play a key part in the plan by focusing efforts on four priority issues: tobacco use, obesity, child health, and behavioral health. For each of these topics, OOMH will develop strategic plans for reducing health disparities. The strategic plan will include an assessment plan to measure progress.

Oklahoma is implementing many activities and initiatives to reduce health disparities and improve health equity. The *A Healthy Baby Begins with You* program is a statewide initiative led by the OOMH in conjunction with the OSDH, Maternal and Child Health Division, as well as local community partners. Together, these state agencies host community baby showers to increase knowledge and educate minority communities about infant mortality and low birthweight. Physicians attend and speak with parents, grandparents, and foster parents about taking care of themselves and the baby before and after pregnancy. Vendors and health care providers help participants find resources and link them to programs. After the shower, the OOMH conducts follow-up calls with attendees to see if they have used the information and resources. Approximately 10 to 20 community showers are conducted throughout Oklahoma each year.

Another initiative led by the OOMH is the *Body and Soul* intervention program, which encourages physical fitness and proper nutrition among African American church members. The office contracts with four African American faith-based institutions and provides technical assistance to implement the program. The intervention lasts between 6 to 12 weeks and is available to congregation members and others in the community.

To learn about the health care needs of racial and ethnic minority communities and devise strategies to reduce health disparities, the OOMH engages the minority community in a series of "community health chats" each year. It picks chat topics based on the targeted community's health needs. Along with a health care professional, the OOMH provides information about the signs and symptoms of targeted health condition, as well as what community members can do to prevent or treat it. Information from the chats helped state officials develop the State Health Improvement Plan. Additional community health chats, focus groups, and key informant interviews related to health disparities and minority health are planned for 2016 to assist in building the OOMH's strategic plan.

To help improve health equity, the OOMH provides interpretation and translation services for populations with limited English proficiency. Two interpreters and translators on staff provide language assistance services to anyone within the office. These services include over the phone and in-person translation/interpreter services as well as translation of OSDH documents. The office also conducts interpretation/translation classes to ensure consistency in the quality of such services within the state and county health departments.

Finally, to educate Oklahomans about minority health and health disparities, the OOMH publishes a *Minority Health at a Glance* report. The report presents statistical data on major health concerns within minority populations in Oklahoma, and is updated annually with new data.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Langston University<br>• Clinton and Lawton Indian Hospital<br>• Latino Community Development Agency<br>• Oklahoma Health Care Authority<br>• Community Health Centers, Inc |
| Contracts or memoranda of understanding with any partners | Yes, memoranda of understanding are implemented for some partnerships. |

The OOMH partners with governmental and nongovernmental agencies and organizations to eliminate health disparities and advance health equity within the state. A primary collaborator is Langston University, a historically black college with whom the OOMH develops initiatives that target the state's African American communities. Additionally, many events are held on the University's campus, including *A Healthy Baby Begins with You* baby showers. The OOMH also provides data from its Minority Health at a Glance report to the University to assist in grant-writing efforts.

Another major collaborator, the Clinton and Lawton Indian Hospital, connects the OOMH with Oklahoma's American Indian communities. The hospital and OOMH work together to bring the OOMH-sponsored baby showers to the American Indian population. As part

of the OOMH's Health Disparities Advisory Coalition, the hospital provides feedback on the office's strategies and components of the Oklahoma Health Improvement Plan to ensure that they address the American Indian population's health care needs.

The relationship with the American Indian community extends beyond the OOMH through the Office of the Tribal Liaison in the Partnerships in Health Improvement division of the OSDH. This office "seeks to demonstrate a respect for sovereignty and advocate for tribal nations while fostering inclusive partnerships using sound public health practices to achieve its vision – 'Achieving Tribal-State Synergy for Optimal Holistic Health' for all Oklahomans."[8] The Office of the Tribal Liaison's work focuses mainly on building government-to-government relationships, but several of its activities incorporate components of minority health and health disparities, and thus overlap with the activities of the OOMH. During the development of the State Health Improvement Plan, the Office of the Tribal Liaison and the OOMH conducted community chats with tribes as a formal consultation regarding health issues, health disparities, and the health needs of the American Indian population. It has also collaborated with the tribes in distributing flu vaccinations, disseminating health information, and conducting safety inspections.

The OOMH also has an ongoing partnership with the Latino Community Development Agency, which assists in disseminating information about the office's programs, such as the community health chats. The agency also provides representation for Latino community on the OOMH's Health Disparities Advisory Coalition.

## Funding

| | |
|---|---|
| Annualized budget (FY 2014) of state/territorial minority health entity (SMHE) across all income sources | $670,000 |
| Annual budget (FY 2014) of SMHE from state/territorial government | Approximately 68% of Office of Minority Health funding comes from state initiatives |
| Largest funding source | State government |
| Anticipated changes to budget in FY 2015 | Yes |

The total FY 2014 funding for the OOMH was $670,000. Its largest funding source was the State of Oklahoma, which allocated $316,075 to its operations. The OOMH also received a $150,000 State Partnership Grant from the U.S. Office of Minority Health. In addition to funding efforts relating to minority health, the State of Oklahoma allocated $203,437 to the OOMH. Since the two offices have overlapping work related to minority health, health disparities, and health equity, funding for the OOMH is included in its annual budget. The OOMH expects its funding allocation to change in FY 2015 due to the end of the State Partnership Grant. OOMH staff anticipate that the State of Oklahoma will allocate additional funding to maintain its programs.

In FY 2014, the OOMH provided funding to the faith-based institutions involved with the *Body and Soul* program as well as to the community partners involved in the *A Healthy Baby Begins with You* program. The office spends an estimated $20,000 a year on funding to nongovernmental, community entities for those two programs.

8 Available on the Oklahoma Department of Health website.

# Oklahoma

## Oklahoma State Data

| Total Population[a]: 3,923,561 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 10.3 | 89.7 | 72.4 | 7.2 | 7.7 | 2.1 | 10.7 | 100.0 | NA |
| Percent of population medically uninsured[a] | 27.2 | 12.7 | 11.2 | 17.8 | 27.6 | 11.0 | 22.8 | 14.2 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 6.1 | 7.3 | 6.6 | 12.1 | 8.6 | SP | NC | 7.3 | 5.9 |
| Age-adjusted mortality rate[b] | 518.6 | 904.0 | 874.5 | 981.3 | 1012.0 | 477.5 | NC | 888.4 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 9.2 | 14.6 | 13.2 | 19.9 | 18.0 | 4.9 | 16.9 | 14.1 | 13.6 |
| Percent with diabetes[c] | 8.7 | 12.3 | 11.4 | 13.7 | 16.4 | 7.3 | 11.4 | 11.9 | 10.8 |
| Percent with heart disease[c] | 2.4 | 5.1 | 5.1 | 2.2 | 5.8 | 0.1 | 5.5 | 4.8 | 4.3 |
| HIV rate[d] | 199.9 | NC | 143.7 | 578.2 | 114.3 | 97.3** | 212.9 | 179.9 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 58.4 | 71.0 | 69.6 | 77.5 | 73.6 | 53.9 | 67.4 | 70.0 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 44.9 | 59.8 | 59.7 | 56.2 | 56.3 | 55.9 | 54.7 | 58.8 | 66.5 |
| Percent received flu vaccine[c] | 24.5 | 42.1 | 41.8 | 38.5 | 41.6 | 37.8 | 32.1 | 40.8 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

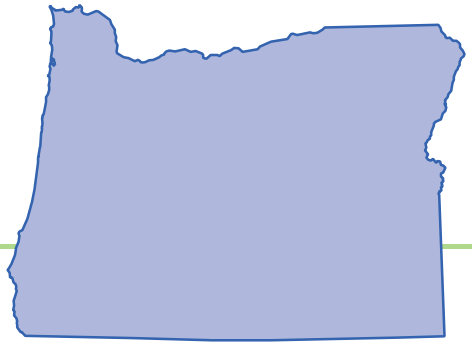
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 97.3 per 100,000 population (67 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 198.0 per 100,000 population (8 cases).

# Oregon



## Introduction to Oregon's Health Equity Activities

Oregon had an estimated 2016 population of 4,093,000. Hispanics/Latinos are the largest racial-ethnic minority population (13 percent), followed by Asian Americans and NHOPI (5 percent), Blacks/African Americans (2 percent), and American Indians/Alaska Natives (1 percent). Persons self-identifying as multiracial or "other race" comprise 8 percent of the population.[1] Approximately 1,072,000 Oregon residents live within a primary care health professional shortage area.[2]

In 2011, the Office of Multicultural Health and Services, which is housed within the Oregon Health Authority (OHA), changed its name to the Office of Equity and Inclusion (OEI) to reflect its broadened focus and goals.[3] The OEI's work focuses on health equity, diversity, inclusion, and civil rights. Its mission is to "work with diverse communities to eliminate health gaps and promote optimal health."[4]

### Oregon Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Equity and Inclusion |
| Strategic plan in place to address minority health or health equity | The *Office of Equity and Inclusion 2011-2016 Strategic Plan* is updated every 5 years. Health equity is also addressed in the *Oregon State Health Improvement Plan, 2015-2019*. |
| Date strategic plan was last updated | 2015 |
| Assessment plan in place to measure progress toward reducing health disparities | • The *Oregon State Health Improvement Plan, 2015-2019* includes measures for each priority.<br>• The *Office of Equity and Inclusion 2011-2016 Strategic Plan* does not include an assessment component.<br>• The Office of Health Analytics helps track health disparity data. |
| Key strategies used to achieve health equity | • Traditional Health Worker Program<br>• Health Care Interpreter Program<br>• Cultural competence continuing education<br>• Developing Equity Leadership through Training and Action (DELTA)<br>• Collection of Race, Ethnicity, Language, and Disability ("REAL+D") data |

## Organizational Structure

The OEI is one of seven units that comprise the OHA. Structurally, it is organized into two focal areas: health equity and diversity and inclusion. The OEI has 21 full-time staff members: the OEI director, the executive manager for health equity, the executive manager for diversity and inclusion, and 18 program staff. Overall, 75 percent of the OEI staff are dedicated to health equity work, while 25 percent are dedicated to diversity and inclusion. In addition to the OEI staff, many in the Public Health Division support health equity initiatives as part of their daily work. Fifteen staff who are members of the Public Health Division's Health Equity Work Group spend 10–15 percent of their time on health equity activities, as does the administrator of the Center for Prevention and Health Promotion. At times, student interns and volunteers support heath disparity reduction activities led by the Public Health Division and the OEI. The Public Health Division has an AmeriCorps Volunteers in Service to America

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.
3 Office of Equity and Inclusion 2011-2016 Strategic Plan. Available on the OEI website. Last accessed 8/4/17.
4 Office of Equity and Inclusion: About Us. Available on the OEI website. Last accessed 8/4/17.

(VISTA) intern, who serves as a health equity coordinator.

A Community Advisory Council (on hiatus at time of data collection) advises the OEI to ensure programmatic alignment with community needs. The OHE's Health Equity Policy Committee, which offers guidance to ensure that OEI programs and policies advance health equity, is transitioning from the OHE to the Oregon Health Policy Board, where its advisory function will expand to support the entire OHA. The Oregon Health Policy Board, a policy-making and oversight body for the OHA, was established in 2009 and is comprised of nine governor-nominated members.[5]

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Office of Equity and Inclusion is one of seven divisions of the Oregon Health Authority. |
| SMHE staffing (full-time equivalents) | 21 |
| Advisory committee or panel | The Community Advisory Council and the Health Equity Policy Committee advise the OEI. |

## Program Goals and Activities

In 2015, the OEI updated its *Office of Equity and Inclusion 2011-2016 Strategic Plan* to clarify its role, vision, and goals. Although it does not include a plan to measure progress towards meeting those goals, the OEI obtains relevant health disparity data from the Office of Health Analytics. A separate report, the *Oregon State Health Improvement Plan, 2015-2019*, includes health equity strategies with specific metrics to assess progress. The OHA's Public Health Division aims to revise the State Health Improvement Plan, with support from an internal Health Equity Work Group, to ensure that strategies take into account racial-ethnic minority populations.

A core function of the OEI is to serve as an advisory body to the OHA on health equity issues. To determine its priorities, the OEI relies upon national and local health disparity data and best practices; it also receives input from the Public Health Division's internal Health Equity Work Group, the Community Advisory Council, the Health Equity Policy Committee, and community coalitions. Because several OEI programs are mandated by state legislation, state lawmakers also help drive OEI's priorities.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Office of Equity and Inclusion | OEI |
| Oregon Health Authority | OHA |

One OEI disparity reduction strategy is to support and promote traditional health workers, such as community health workers, peer support specialists, personal health navigators, and birth doulas. The Traditional Health Worker Program, managed by the OEI, helps train and certify providers to ensure culturally responsive care and improve minority health.

Language access and cultural competence are other focus areas of the OEI. Its Health Care Interpreter Program provides resources for health care interpreters seeking to meet qualifications for certification. Through this program, the OEI monitors training programs, which are reviewed by a committee of governor-approved individuals. Programs that meet the committee's criteria are publicly shared—OEI staff add trainings that meet the criteria to an online registry.[6] Relatedly, the OEI is required by law[7] to provide support and resources aimed at improving the cultural competence of Oregon's health care providers. As part of this mandate, the OEI also monitors and provides reports on provider participation in cultural competence-related continuing education. The OEI also manages Developing Equity Leadership through Training and Action (DELTA), a training program to prepare leaders in health equity and diversity. Each cohort includes 20–25 participants from various backgrounds and a program curriculum spanning 9 months. Trainings cover a range of topics such as health equity metrics, community engagement, and language access, and participants must submit a project to enhance health equity in their respective organizations.[8]

5 See the Oregon Health Policy Board: Members page on the OHA's website. Last accessed 8/4/2017.
6 Office of Equity and Inclusion. Cultural Competence Continuing Education (CCCE): HB 2611 (2013). Available on the OEI website. Last accessed 8/4/17.
7 2015 ORS 413.450, Continuing education in cultural competency. Available through OregonLaws.org. Last accessed 8/4/17.
8 See the Office of Equity and Inclusion's Developing Equity Leadership through Training and Action (DELTA) webpage. Available on the OEI website. Last accessed 8/4/17.

Another priority for the OEI is promoting the collection of race, ethnicity, language, and disability ("REAL+D") demographic data. The OHA is mandated to collect REAL+D data when feasible and is working to standardize its collection and analysis to efficiently identify and respond to health disparities.

The Public Health Division also implements interventions designed to reduce health disparities. For example, as part of its statewide obesity prevention plan, it is working to increase access to parks and recreation facilities for low socioeconomic and minority populations.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Multnomah County Health Department<br>• Oregon legislative system<br>• Regional Health Equity Coalitions<br>• Community-based organizations<br>• Nine federally recognized tribes<br>• Northwest Portland Area Indian Health Board |
| Contracts or memoranda of understanding with any partners | Yes, contracts are implemented for some partnerships (e.g., with several Regional Health Equity Coalitions and federally recognized tribes). |

The OEI partners with various organizations to advance health equity in Oregon. The Multnomah County Health Department is a key partner, particularly around health care access issues. Much of the collaborative work aims to improve the health of both of refugee populations and of those enrolled in the Oregon Health Plan. In addition, the OEI partners with the legislature on health policy work. In this role, the OEI assesses whether new bills might have unintended consequences for minority populations, and whether any revisions in legislation could enhance health equity outcomes.

Regional Health Equity Coalitions collaborate with the OEI to advance local health equity. The coalitions focus on identifying and addressing regional health disparities, while focusing state-level priorities. One of the coalitions, the Oregon Health Equity Alliance, advocates for legislative and policy work to advance health equity. The OEI and the Oregon Health Equity Alliance are working on the Cover All Kids initiative to ensure health insurance coverage for all Oregon youth. The OEI also partners with community-based organizations that serve as training entities for traditional health workers or health care interpreters.

To eliminate disparities and advance the health of Oregon's Native American tribal populations, the Public Health Division partners with Oregon's nine federally recognized Native American tribes and the Northwest Portland Area Indian Health Board. The Public Health Division works with tribes on public health goals, including emergency preparedness, child vaccinations, and tobacco prevention. In addition, state legislation mandates monthly meetings between Oregon tribal health leaders and OHA staff to discuss health and policy issues.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $3,400,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | Undetermined |
| Largest funding source | State government |
| Anticipated changes to budget | None |

Total FY 2015 funding for the OEI was approximately $3,400,000 from state and federal sources; this covers both staff salaries and OEI activities. State general funds are the largest source of funding for the OEI. During FY 2015, the OEI also received State Innovation Model (SIM) funding from the U.S Centers for Medicare and Medicaid Services to support health equity initiatives. The OHA's Public Health Division's budget does not include a separate line item for health equity activities, but $726,181 was earmarked for salaries of the staff who are members of the Health Equity Work Group.

In FY 2015, the OEI allocated $125,000 to each of the six Regional Health Equity Coalitions to support local project implementation. During that same year, the OEI provided grant funding up to $2,500 per organization to community-based and nonprofit organizations for health equity projects and activities. The Public Health Division also provides funding to Oregon's nine federally recognized Native American tribes for public health activities.

# Oregon

## Oregon State Data

| Total Population[a]: 4,093,465 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 12.8 | 87.2 | 84.3 | 1.9 | 1.2 | 4.6 | 8.0 | 100.0 | NA |
| Percent of population medically uninsured[a] | 14.9 | 5.3 | 6.1 | 7.5 | 13.5 | 6.3 | 9.8 | 6.5 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 3.6 | 5.4 | 4.9 | SP | SP | SP | NC | 5.2 | 5.9 |
| Age-adjusted mortality rate[b] | 454.8 | 715.8 | 715.1 | 738.2 | 664.3 | 443.7 | NC | 705.9 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 18.2 | 17.0 | 16.9 | 25.5 | 29.2 | 9.4 | 20.5 | 17.3 | 13.6 |
| Percent with diabetes[c] | 12.4 | 9.2 | 9.2 | 14.7 | 13.3 | 8.0 | 10.6 | 9.4 | 10.8 |
| Percent with heart disease[c] | 2.7 | 4.6 | 4.5 | 5.3 | 10.4 | 1.1 | 3.2 | 4.5 | 4.3 |
| HIV rate[d] | 236.1 | NC | 181.2 | 761.6 | 124.6 | 84.2** | 234.0 | 193.7 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 60.6 | 66.4 | 66.3 | 67.1 | 63.2 | 67.4 | 63.7 | 66.1 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 60.9 | 69.2 | 68.7 | 72.6 | 74.1 | 69.2 | 68.7 | 68.9 | 66.5 |
| Percent received flu vaccine[c] | 27.4 | 36.6 | 36.4 | 24.5 | 34.0 | 40.1 | 32.6 | 36.0 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

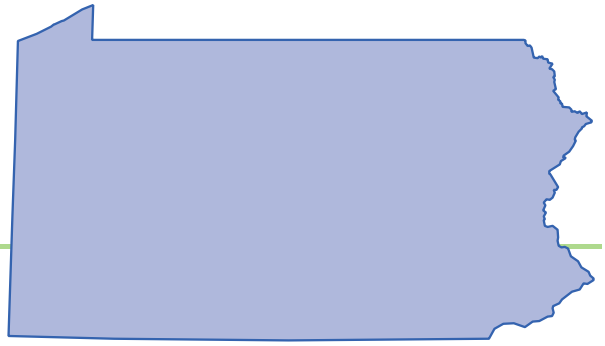
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 84.2 per 100,000 population (123 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 151.5 per 100,000 population (19 cases).

# Pennsylvania



## Introduction to Pennsylvania's Health Equity Activities

Pennsylvania had an estimated 2016 population of 12,784,000. Blacks/African Americans are the largest racial-ethnic minority population (11 percent), followed by Hispanics/Latinos (7 percent), Asian Americans and NHOPI (3 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 4 percent of the population.[1] Approximately 728,000 Pennsylvania residents live within a primary care health professional shortage area.[2]

In 2007, an executive order formally integrated the Office of Health Equity (OHE) into the Pennsylvania Department of Health (PADOH). As mentioned in its authorizing executive order, the OHE is to be a leader in increasing public awareness about health disparities; address health disparities by advocating for program development; work with policymakers, health care providers, insurers, and communities to implement programs and policies that cause a sustained and measured improvement in health status of disparate and underserved populations; and collaborate with academic institutions, providers, community-based organizations, state agencies, and others to eliminate health disparities.[3] The OHE focuses on racial and ethnic minorities, as well as other vulnerable populations.

### Pennsylvania Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Health Equity |
| Strategic plan in place to address minority health or health equity | The Office of Health Equity has a strategic plan regarding minority health, health disparities, and health equity. |
| Date strategic plan was last updated | The Office of Health Equity is developing an updated version of its strategic plan. |
| Assessment plan in place to measure progress toward reducing health disparities | There are currently no plans to integrate an assessment plan into the strategic plan. |
| Key strategies used to achieve health equity | • Public Health 3.0<br>• Pennsylvania Interagency Health Equity Team<br>• Implementation of National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) |

## Organizational Structure

In 2007, an executive order formally integrated the OHE into the PADOH. An OHE Advisory Committee, which consists of 16 experts who volunteer from across Pennsylvania, provides guidance to Pennsylvania's secretary of health on issues around health inequality. The Advisory Committee recommends activities that are evidence-based, data-driven, and culturally aware. It also works to increase health disparity public awareness and helps organize individuals and community actions to eliminate health disparities.[4]

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.
3 Commonwealth of Pennsylvania Governor's Office, Executive Order. Subject: Office of Health Equity. Number: 2007-04. Date: May 21, 2007. Signed by Edward G. Rendell, Governor. Available on the Pennsylvania Office of Administration's website. Last accessed 8/4/2017.
4 Office of Health Equity Advisory Committee. Office of Health Equity Advisory Committee 2016-2018. Available through the Pennsylvania Department of Health website. Last accessed 8/4/2017.

The OHE has one full-time staff member, the OHE director, who spends 100 percent time on minority health, health disparities, and health equity issues. Two PADOH staff also spend a portion of their time on OHE initiatives and activities, as do two unpaid student interns. The OHE anticipates possible staff increases in the next two years.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The OHE is housed within the Pennsylvania Department of Health |
| SMHE staffing (full-time equivalents) | 1 |
| Advisory committee or panel | Office of Health Equity Advisory Committee |

## Program Goals and Activities

The OHE is updating its strategic plan for addressing minority health, health disparities, and health equity—initially developed in 2010. Once complete, the OHE's document will be integrated into ongoing PADOH-level strategic planning. One part of the OHE's strategic plan will be a health equity report, which will include factors related to social determinants of health. In setting its priorities, the OHE is informed by several key sources, including data from the Robert Wood Johnson Foundation's County Health Rankings and the Behavioral Risk Factor Surveillance System. County Health Rankings, available online,[5] assess essential health factors including obesity, smoking, high school graduation rates, access to healthy foods, unemployment, income inequality, teen births, and the quality of air and water.[6] The Behavioral Risk Factor Surveillance System is a national survey that collects data on chronic health conditions, health-related risk behaviors, and preventive services use. Other contributors to the OHE's priority-setting process include the PADOH and other stakeholders.

The OHE has several major strategies to improve the health of minority populations and eliminate disparities: Public Health 3.0, a new Pennsylvania Interagency Health Equity Team, and implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). Public Health 3.0 is a national initiative to build innovative partnerships to address all aspects of life that promote well-being and health. It promotes cross-sector environmental, policy, and systems-level actions to affect the social determinants of health and advance health equity.[7] The OHE uses the County Health Rankings and the Behavioral Risk Factor Surveillance System data to identify regions with the worst health outcomes. It then hosts periodic meetings in these areas, engaging with cross-sector partners to assess progress toward improved health outcomes. Between meetings, the OHE works with several community organizations within these regions to obtain information on health outcomes and provide technical assistance.

Also as part of its strategy, the OHE is developing the Pennsylvania Interagency Health Equity Team. A replication of the Federal Interagency Health Equity Team,[8] the Pennsylvania Interagency Health Equity Team has representation from state agencies with the goal of increasing cross-sector equity. First convened in 2017, the Pennsylvania Interagency Health Equity Team seeks to share data on inequalities across sectors to develop collaborative projects to address previously unrecognized gaps and to align activities across agencies.

The OHE is also implementing National CLAS standards and is working within the PADOH to meet all of the National CLAS Standards. In addition, together with the PADOH, the OHE is working toward national accreditation.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Pennsylvania Department of Health | PADOH |
| Office of Health Equity | OHE |

5 "County Health Rankings and Roadmaps: Building a Culture of Health, County by County." Funded by the Robert Wood Johnson Foundation. Available online. Last accessed 8/4/2017.

6 "County Health Rankings and Roadmaps-About." Funded by the Robert Wood Johnson Foundation. Available online. Last accessed 8/4/2017.

7 "Public Health 3.0." Office of Disease Prevention and Health Promotion. Available through the Health People 2020 website. Last accessed 8/4/2017.

8 "Federal Interagency Health Equity Team." National Partnership for Action to End Health Disparities. Available on the U.S. Office of Minority Health Website. Last accessed 8/4/2017.

# Pennsylvania

### Partnerships

| | |
|---|---|
| Primary collaborators | • Department of Aging<br>• Department of Agriculture<br>• Department of Community and Economic Development<br>• Department of Conservation and Natural Resources<br>• Department of Corrections<br>• Department of Education<br>• Department of Health<br>• Department of Human Services<br>• Department of Labor and Industry<br>• Department of Transportation<br>• Pennsylvania Association of Community Health Centers |
| Contracts or memoranda of understanding with any partners | No partnerships include formal contracts or memoranda of understanding. |

The OHE partners with a wide range of organizations, both within and outside of state government, in its efforts to advance health equity. As part of the Pennsylvania Interagency Health Equity Team, the OHE informally collaborates with representatives from the following state agencies: Department of Aging, Department of Agriculture, Department of Community and Economic Development, Department of Conservation and Natural Resources, Department of Corrections, Department of Education, Department of Health, Department of Human Services, Department of Labor and Industry, and Department of Transportation. These agencies work together to share data and develop collaborative projects. For instance, as part of the Diversity Day project, the Pennsylvania Interagency Health Equity Team seeks to encourage minority population use of Pennsylvania's state parks by coordinating cultural competency trainings for park staff. It also has been working with the Pennsylvania Parks and Forest Foundation to hold a health summit and to develop the Diversity Day project. The OHE is collaborating with transportation stakeholders to have health be a consideration in local transportation planning.

To support the WalkWorks Program—which focuses on increasing physical activity to combat childhood obesity and other chronic conditions and establishes safe walking routes throughout Pennsylvania—the OHE informally collaborates across departments and sectors. The OHE's WalkWorks partners include the PADOH, Department of Conservation and Natural Resources, Department of Transportation, University of Pittsburgh Graduate School of Public Health, and other governmental and nongovernmental organizations.[9] The OHE also works with the Department of Transportation to encourage health considerations in local transportation planning and to assess the need for more crosswalks, sidewalks, and bike lanes in at-risk communities.

In addition, the OHE shares information and data with the Department of Conservation and Natural Resources and the Department of Education to help identify and address opportunities for improvement initiatives. It also collaborates with the Pennsylvania Association of Community Health Centers to share opportunities, promote health equity activities, and provide related trainings.

## Funding

| | |
|---|---|
| Annual budget (FY 2017) of state/territorial minority health entity (SMHE) across all income sources | $137,000 |
| Annual budget (FY 2017) of SMHE from state/territorial government | $137,000 |
| Largest funding source | State government |
| Anticipated changes to budget | Potential for Increase |

The total FY 2015 funding for the OHE was $137,000. The Pennsylvania state government fully funds the OHE and the OHE does not fund nongovernment organizations. The OHE anticipates possible funding increases in the next 2 years.

9 "WalkWorks." Available on the Pennsylvania Department of Health website. Last accessed 8/4/2017.

# Pennsylvania

## Pennsylvania State Data

| Total Population[a]: 12,784,227 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 7.0 | 93.0 | 80.9 | 11.0 | 0.3 | 3.3 | 4.5 | 100.0 | NA |
| Percent of population medically uninsured[a] | 14.8 | 5.6 | 5.5 | 9.1 | 9.4 | 6.3 | 12.3 | 6.3 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 6.3 | 5.8 | 5.2 | 10.8 | SP | 4.7 | NC | 6.2 | 5.9 |
| Age-adjusted mortality rate[b] | 547.7 | 771.4 | 762.9 | 927.7 | 206.4 | 383.6 | NC | 770.1 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 24.4 | 14.3 | 13.4 | 22.0 | 25.5 | 9.8 | 24.0 | 14.6 | 13.6 |
| Percent with diabetes[c] | 12.2 | 11.2 | 11.0 | 15.7 | 3.7 | 5.1 | 8.5 | 11.2 | 10.8 |
| Percent with heart disease[c] | 3.3 | 4.7 | 4.8 | 5.2 | 1.9 | 0.5 | 4.0 | 4.6 | 4.3 |
| HIV rate[d] | 870.6 | NC | 119.1 | 1474.8 | 203.1 | 71.1** | 1224.2 | 314.4 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 72.8 | 73.7 | 73.0 | 83.0 | 66.1 | 62.4 | 64.5 | 73.6 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 64.3 | 66.9 | 68.6 | 56.9 | 60.3 | 8.0 | 58.7 | 67.0 | 66.5 |
| Percent received flu vaccine[c] | 32.4 | 43.6 | 43.1 | 42.8 | 39.6 | 47.2 | 30.8 | 42.9 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 71.1 per 100,000 population (250 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 707.9 per 100,000 population (22 cases).

# Puerto Rico

## Introduction to Puerto Rico's Health Equity Activities

Puerto Rico had an estimated 2016 population of 3,411,000. Hispanics/Latinos are the largest racial-ethnic minority population (99 percent), followed by Blacks/African Americans (12 percent).* Persons self-identifying as multiracial or "other race" comprise 21 percent of the population.[1]

The Puerto Rico Department of Health (DOH) is responsible for preserving and promoting the health of all Puerto Ricans. Its responsibilities range from public health service coordination to managing several hospitals and clinics where DOH staff provide direct patient care. Given Puerto Rico's racial and ethnic composition, activities targeting health equity activities are standard practice throughout DOH programs.

### Puerto Rico Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Puerto Rico Department of Health |
| Strategic plan in place to address minority health or health equity | *Department of Health Strategic Plan, 2011-2018* |
| Date strategic plan was last updated | 2011 |
| Assessment plan in place to measure progress toward reducing health disparities | *The Department of Health Strategic Plan, 2011-2018* includes strategic goals and an evaluation plan. |
| Key strategies used to achieve health equity | • Improving access to health care<br>• Conducting municipality visits<br>• Delivering specialized services to crime victims<br>• Leading HIV and tuberculosis programs<br>• Obtaining federal funding to support public health activities |

## Organizational Structure

Charged with preserving and promoting the health and well-being off all Puerto Ricans, the DOH is responsible for a wide range of health care activities. The Department is organized into 11 units: Auxiliary Secretariat for Family Health and Integrated Services, Assistant Secretary for Health Promotion, Assistant Secretary for Medical Services and Nursing, Assistant Secretary of Environmental Health and Public Health Laboratories, Assistant Secretary for Planning and Development, Secretariat of Health Facilities Accreditation, Office of Preparation and Coordination of Response in Public Health, Research Office, Office of Epidemiology and Research, Commission for Suicide Prevention, and Food and Nutrition Commission of Puerto Rico.[2] A council advises the Secretary of Health on issues related to the health of Puerto Ricans.

In total, the DOH employs 4,833 staff members, including clinicians who provide direct patient care and administrators who support operations at public hospitals and clinics. Most DOH employees spend at least some portion of their workday addressing minority health issues and advancing health equity. Its staff is funded with a combination of state and federal

* Note: The Hispanic/Latino ethnic category is not mutually exclusive with racial categories.

1 American Community Survey Public Use Microdata, 2016.

2 Puerto Rico Department of Public Health. Operational Units. Available on the Commonwealth of Puerto Rico Department of Health's website. Last accessed 8/4/2017.

funding. A proposed voluntary retirement plan, under consideration because of budgetary concerns, is expected to decrease DOH staff—particularly direct-care nurses.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The DOH reports to the Secretary of Health, who oversees the Department and reports to the Governor of Puerto Rico. |
| SMHE staffing (full-time equivalents) | The DOH has 4,833 employees, including hospital and clinic health care providers. Many support population health initiatives. |
| Advisory committee or panel | Yes. A council directly advises the Secretary of Health. |

## Program Goals and Activities

The *Puerto Rico Department of Health Strategic Plan, 2011-2018* includes strategic objectives to promote health equity, reduce disparities, and improve overall population health. It includes specific strategic goals and anticipated evaluation activities, including the frequency of assessments monitoring progress on those goals.

To identify departmental priorities, the DOH reviews available data and program reports and engages with a wide array of stakeholders. The DOH solicits feedback during strategic planning efforts on the current priorities of community members, academics, religious groups, and partner organizations. In 2015, the Governor of Puerto Rico signed an executive order that brought attention to health equity. Since then, several laws have been enacted to protect health and reduce health disparities.

A separate report, the *Puerto Rico Healthy People 2020 Strategic Plan,* which was last updated in 2012, also guides the DOH in selecting and addressing priorities.[3] The Healthy People 2020 plan focuses on priority health conditions; nutrition and physical activity; maternal, infant, and child health; mental health and substance abuse; and older adults. For each priority area, the Healthy People 2020 plan lists strategies to achieve the stated goals. In addition, the DOH has a 10-year (2016 through 2026) comprehensive health plan for the Commonwealth.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Department of Health | DOH |

One key priority for the DOH is reducing disparities in access to health care. Representatives from the DOH and other agencies visit municipalities at least annually, allowing DOH staff to both learn about constituent communities and educate residents about the services offered through DOH programs. The DOH seeks to provide a broad range of interventions for particularly vulnerable, underserved, and special populations. For example, the DOH sponsors an office that focuses exclusively on treatment and assistance for crime victims. In addition to providing direct medical intervention for crime victims, its staff collaborate with the Puerto Rico Department of Education to conduct tailored educational programming for various audiences on prevention of violence, sexual assault, and other crimes.

Other interventions include the DOH's HIV program and Ryan B White Programs, which aim to prevent the spread of HIV and treat HIV-positive individuals. Staff from the Family Health and Integrated Services Unit of the DOH conduct outreach to promote HIV testing in the homeless population; the lesbian, gay, bisexual, and transgender population; and others at high risk of HIV. Likewise, staff from the Family Health and Integrated Services Unit lead a tuberculosis program that targets at-risk populations. Program staff provide educational resources and tuberculosis testing to communities and conduct epidemiologic investigations upon disease detection.

Another core focus for DOH staff working on health equity issues involves obtaining external financial support. Staff throughout the DOH work to identify funding opportunities that can address health needs and reduce health disparities in Puerto Rico. Such opportunities often relate to chronic disease prevention, emerging diseases, and community outreach. The DOH includes professionals to assist staff in responding to federal funding opportunities that could support or expand DOH initiatives.

3 Puerto Rico Health People 2020 Strategic Plan: Promoting Healthy Living. Available on the Commonwealth of Puerto Rico Department of Health's website. Last accessed 8/4/2017.

# Puerto Rico

### Partnerships

| | |
|---|---|
| Primary collaborators | • American Red Cross<br>• Association of State and Territorial Health Officials<br>• Centers for Disease Control and Prevention<br>• Centers for Medicare & Medicaid Services<br>• Health Resources and Services Administration<br>• Puerto Rico Medical Association<br>• Schools of medicine, pharmacy, and public health |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

The DOH partners with governmental and non-governmental organizations to promote health equity in Puerto Rico. Federal partners include the Centers for Disease Control and Prevention, the Health Resources and Services Administration, and the Centers for Medicare and Medicaid Services. These agencies provide the DOH with funding, technical assistance with program implementation, and guidance on emerging issues. The Association of State and Territorial Health Officials assists the DOH with training staff and accreditation processes and the American Red Cross assists on blood banking and disaster prevention activities.

In addition to these national partners, the DOH collaborates with organizations based within Puerto Rico, including academic institutions and nonprofit groups. The DOH has contracts in place with the local medical school, pharmacy school, and public health school. Joint activities include research on the incidence of the Zika virus in pregnant women and its sequelae in children. To prevent the spread of the Zika virus, the DOH is working with a nonprofit organization to educate women of childbearing age about transmission and prevention.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $741,431,000 (includes budget for direct patient care services) |
| Annual budget (FY 2015) of SMHE from state/territorial government | $354,691,000 (includes revenue from direct patient care services) |
| Largest funding source | Territorial government and patient care revenues (which includes federal Medicare and Medicaid dollars) |
| Anticipated changes to budget | Unknown |

In FY 2015, funding to support all DOH activities and operations, including clinical support, totaled $741,431,000. Territorial government allocations and patient service revenue constituted the largest source of funding, followed by the federal government. The DOH contracts with local, nonprofit organizations to provide services to special populations, such as HIV-positive individuals and drug users. Funding supports nonprofits conduct outreach and provide education in at-risk communities.

# Puerto Rico

## Puerto Rico Territory Data

| Total Population[a]: 3,411,307 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 98.6 | 1.4 | 66.9 | 11.6 | 0.3 | 0.1 | 21.1 | 100.0 | NA |
| Percent of population medically uninsured[a] | 8.7 | 6.4 | 5.7 | 8.1 | 5.5 | 23.4 | 7.5 | 6.4 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | NC | NC | NC | NC | NC | NC | 7.0 | 5.9 |
| Age-adjusted mortality rate[b] | NC | NC | NC | NC | NC | NC | NC | 624.7 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 17.5 | 26.4 | 17.7 | 19.0 | SP | SP | 17.1 | 17.5 | 13.6 |
| Percent with diabetes[c] | 15.3 | 20.4 | 16.5 | 9.6 | SP | SP | 14.8 | 15.3 | 10.8 |
| Percent with heart disease[c] | 7.8 | 6.1 | 8.3 | 7.8 | SP | SP | 6.8 | 7.7 | 4.3 |
| HIV rate[d] | NC | NC | NC | NC | NC | NC | NC | 564.0 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 82.3 | 78.3 | 84.3 | 84.6 | SP | SP | 79.0 | 82.3 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 69.5 | 74.7 | 71.7 | 76.9 | SP | SP | 64.8 | 69.5 | 66.5 |
| Percent received flu vaccine[c] | 25.3 | 11.9 | 26.7 | 26.4 | SP | SP | 22.8 | 25.2 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015.

*Native Hawaiian and other Pacific Islander

# Rhode Island

## Introduction to Rhode Island's Health Equity Activities

Rhode Island had an estimated 2016 population of 1,056,000. Hispanics/Latinos (15 percent) are the largest racial-ethnic minority population, followed by Blacks/African Americans (6 percent), Asian Americans and NHOPI (4 percent), and American Indians/Alaska Natives (1 percent). Persons self-identifying as multiracial or "other race" comprise 9 percent of the population.[1] Approximately 162,000 Rhode Island residents live within a primary care health professional shortage area.[2]

The Rhode Island Department of Health (RIDOH) Health Equity Institute (HEI) was created explicitly to advance health equity. Its mission is to "promote access to comprehensive, high quality services so that all Rhode Islanders may achieve their optimal state of health."[3] Located within the RIDOH Director's Office, the HEI seeks to advance health equity across all RIDOH programs and policies.

### Rhode Island Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Health Equity Institute |
| Strategic plan in place to address minority health or health equity | *Rhode Island Department of Health Strategic Framework* |
| Date strategic plan was last updated | 2016 |
| Assessment plan in place to measure progress toward reducing health disparities | The *Rhode Island Department of Health Strategic Framework* includes measurable objectives. |
| Key strategies used to achieve health equity | • Championing population health goals<br>• Supporting the Health Equity Zone project<br>• Supporting community health workers as change agents |

## Organizational Structure

Within the RIDOH, the HEI is located in the Director's Office. HEI has 11 full-time staff members, including a director, a Minority Health lead, a disability and health program manager, a Health Equity Zone manager, a refugee health coordinator, a minority youth mentoring manager, a maternal and child health program manager, an evaluator/epidemiologist, an outreach worker, a communications manager, and a systems coordinator. The HEI anticipates staffing allocations to change following expiration of grants. The Commission for Health Advocacy and Equity was legislatively established and serves as an advisory council both to the RIDOH generally and the HEI in particular.

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.
3 Information about the Health Equity Institute is available from the Rhode Island Department of Health's website. Last accessed October 22, 2017.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Health Equity Institute is housed within the Rhode Island Department of Health Director's Office |
| SMHE staffing (full-time equivalents) | 11 |
| Advisory committee or panel | Commission for Health Advocacy and Equity |

## Program Goals and Activities

The *Rhode Island Department of Health Strategic Framework* serves as the RIDOH's "blueprint" for reducing health disparities and achieving health equity. It identifies three leading priorities or directives to help the state achieve its population health goals: (1) address the social and environmental determinants of health, (2) eliminate health disparities and promote health equity, and (3) ensure access to quality health services, including vulnerable populations. Each of the RIDOH's 23 population health goals and targets is associated with a specific RIDOH area or program and has been incorporated into an Integrated Population Health Plan as part of Rhode Island's State Innovation Model (SIM) Test Grant Operational Plan. The RIDOH also developed metrics associated with each population health goal to measure improvement over time. Disparities identified through data analyses of metric data help determine specific health equity priorities for the RIDOH.

To that end, a key HEI strategy is to support the RIDOH in championing Rhode Island's population health goals. The HEI works with RIDOH programs and staff to increase their capacity to address disparities and advance health equity. In an effort to support this strategy, the HEI developed a health equity training series, featuring training videos and facilitated discussions with RIDOH staff.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Health Equity Institute | HEI |
| Rhode Island Department of Health | RIDOH |

Another major HEI strategy involves supporting the Health Equity Zone project, which aims to prevent chronic diseases, improve birth outcomes, and improve the social and environmental conditions in nine geographic areas throughout Rhode Island. Within each Health Equity Zone, the HEI helps build a network of municipal leaders, residents, businesses, transportation and community planners, law enforcement, education systems, and health systems that collaborate on developing and implementing action plans for their communities.

The HEI also leads an effort to support community health workers as change agents. To facilitate implementation of this strategy the HEI worked with the Rhode Island Certification Board to create a Certified Community Health Worker credential aimed at standardizing education and scopes of practice, integrating community health workers into the health system, and improving visibility and job stability. A larger goal of the certification credential is to develop a labor force capable of reducing disparities by linking clinical issues to community social determinants of health.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Brown University School of Public Health<br>• Health Equity Zone partners<br>• Rhode Island College<br>• Rhode Island Department of Health divisions and programs<br>• Rhode Island Executive Office of Health and Human Services<br>• Rhode Island Parent Information Network<br>• University of Rhode Island |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

The HEI partners with a variety of governmental, nongovernmental, academic, and other organizations to advance health equity in Rhode Island. For example, to support the community health worker certification program, the RIDOH engaged in a formal partnership with Rhode Island College. The RIDOH and the HEI also work closely with the Rhode Island Parent Information Network, a contracted organization that hires, trains,

and supports community health workers. To support its efforts, the RIDOH has established formal partnerships with other academic institutions, as well, including the Brown University School of Public Health and the University of Rhode Island. Other HEI collaborators include the Rhode Island Executive Office of Health and Human Services and many divisions and programs within the RIDOH. Each Health Equity Zone engages a collaborative of diverse partners that include municipal leaders, residents, businesses, transportation, local housing authorities, health care partners including mental health community centers, payers, hospitals, community planners, law enforcement, education systems, among others.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $3,725,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $425,000 |
| Largest funding source | Federal government |

The total FY 2015 funding for the HEI was $3,725,000. The HEI received several federal grants in FY 2015, including a State Partnership Initiative to Address Health Disparities (SPI) grant ($200,000); a Title V Maternal and Child Health Services Block Grant Program ($1,700,000); a federal Preventive Health and Health Services Block Grant ($800,000); and a Systems Integration Project for Children and Youth with Special Healthcare Needs grant ($300,000). The HEI received $425,000 in state funding in FY 2015, and approximately $300,000 from Medicaid administrative funds. The HEI provided $2,400,000 to the Health Equity Zone project in FY 2015.

# Rhode Island

## Rhode Island State Data

| Total Population[a]: 1,056,426 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 15.0 | 85.1 | 81.0 | 6.2 | 0.5 | 3.6 | 8.7 | 100.0 | NA |
| Percent of population medically uninsured[a] | 10.5 | 3.1 | 3.2 | 6.1 | 21.9 | 4.0 | 11.4 | 4.2 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 5.5 | 5.1 | SP | SP | SP | NC | 5.9 | 5.9 |
| Age-adjusted mortality rate[b] | 417.5 | 705.4 | 708.5 | 471.8 | 641.4 | 356.5 | NC | 690.1 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 17.9 | 15.5 | 16.0 | 15.3 | 11.0 | 10.5 | 18.0 | 15.9 | 13.6 |
| Percent with diabetes[c] | 8.3 | 10.1 | 10.2 | 9.6 | 17.4 | 3.0 | 8.9 | 9.9 | 10.8 |
| Percent with heart disease[c] | 2.4 | 4.2 | 4.3 | 1.7 | 1.3 | 3.4 | 4.2 | 4.1 | 4.3 |
| HIV rate[d] | 540.9 | NC | 155.1 | 1100.8 | 189.9 | 126.1** | 424.0 | 259.5 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 78.7 | 82.5 | 83.1 | 74.6 | 87.7 | 81.1 | 79.0 | 82.3 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 66.9 | 77.8 | 78.9 | 66.0 | 71.2 | 75.1 | 58.9 | 76.6 | 66.5 |
| Percent received flu vaccine[c] | 39.4 | 47.6 | 47.6 | 41.2 | 54.8 | 53.2 | 35.6 | 46.6 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

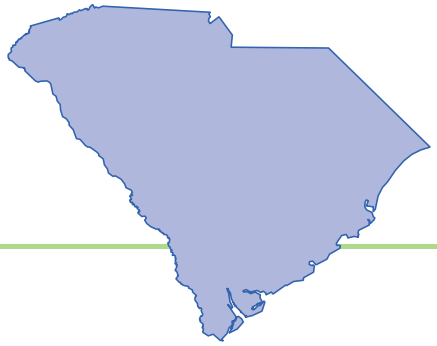
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 126.1 per 100,000 population (38 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 174.5 per 100,000 population (1 case).

# South Carolina



## Introduction to South Carolina's Health Equity Activities

South Carolina had an estimated 2016 population of 4,961,000. Blacks/African Americans are the largest racial-ethnic minority population (27 percent), followed by Hispanics/Latinos (6 percent), Asian Americans and NHOPI (2 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 4 percent of the population.[1] Approximately 2,231,000 South Carolina residents live within a primary care health professional shortage area.[2]

The South Carolina Department of Health and Environmental Control (DHEC)'s Office of Health Equity (OHE) was created to address minority health and health disparities. Located within the Health Services Division of the DHEC, the OHE reports directly to the division's chief of staff.

### South Carolina Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Health Equity |
| Strategic plan in place to address minority health or health equity | The Office of Health Equity does not have an updated strategic plan. The Health Services Division is deciding whether to incorporate health equity strategies into the Health Services Division's strategic plan or create a standalone strategic plan for the Office of Health Equity. |
| Date strategic plan was last updated | The Office of Health Equity does not have a standalone strategic plan. |
| Assessment plan in place to measure progress toward reducing health disparities | The Office of Health Equity does not have an assessment plan in place. |
| Key strategies used to achieve health equity | • Increase awareness of health disparities<br>• Re-engage community partners<br>• Provide trainings on cultural competency and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care<br>• Improve breast and cervical screening of African and Native American women<br>• Increase minority participation in the AIDS Drug Assistance Program and HIV/AIDS medical care and treatment |

## Organizational Structure

Housed within the DHEC's Health Services Division, the OHE reports to the Health Services Division chief of staff, who reports to the division's director. The OHE has two staff members who work full time on minority health initiatives: a cultural competency consultant and an equity and disparities consultant. Plans are underway to fill the currently vacant OHE program director position in the near term. Approximately 10 percent of the Health Services Division's chief of staff effort is on minority health initiatives. Student interns support the OHE at times. In addition, employees throughout the DHEC work to advance health equity as part of their daily work, including staff within the Bureau of Community Health and Chronic Disease Prevention and the Bureau of Maternal and Child Health.

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Office of Health Equity is located within the Health Services Division of the South Carolina Department of Health and Environmental Control. |
| SMHE staffing (full-time equivalents) | 3 |
| Advisory committee or panel | None |

## Program Goals and Activities

In 2016, the Health Services Division embarked on a priority-setting initiative with support from an external contractor. The effort culminated in a report that highlighted priorities for the division, including OHE priorities. Subsequently, the Health Services Division began selecting priorities and discussing whether the OHE should create a stand-alone health equity strategic plan. The Health Services Division plans to establish methods for measuring outcomes associated with each identified priority to track progress. Some grant activities require health equity data monitoring.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Office of Health Equity | OHE |
| Department of Health and Environmental Control | DHEC |

Although the OHE does not have its own strategic plan, the office is leading various health equity strategic planning activities. For example, the OHE participated in a 2-day session focused on health disparities and OHE priorities. During the session, the OHE engaged external and internal stakeholders, and received technical assistance from the Association of State and Territorial Health Officials. The purpose of the session was for the OHE to gather information to drive development of a stand-alone strategic plan or a plan for integrating OHE strategic initiatives into the more comprehensive strategic plan of the Health Services Division.

Organizations that play an ongoing role in identifying health equity priorities include the Alliance for a Healthier South Carolina, the South Carolina Commission for Minority Affairs, and the South Carolina Institute of Medicine and Public Health.

To improve the health of minority populations and eliminate disparities, the OHE promotes public awareness of health disparities and works with staff across the DHEC to ensure that efforts are appropriate for targeted populations. DHEC "lunch and learn" events educate staff about health disparities and how DHEC efforts help to achieve health equity. During National Minority Health Month, the OHE develops content for the DHEC's public blog to raise awareness of health disparities. The OHE aims to re-engage community partners, such as the Urban League. Re-engagement opportunities allow the OHE and the Health Services Division to update partners on current activities and request ongoing support.

OHE staff members lead efforts to educate DHEC staff on cultural competency and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). All DHEC staff are required to complete an online training module—developed by the OHE—that focuses on cultural competency. In addition, the OHE is responsible for providing National CLAS Standards trainings to staff responsible for direct client services.

Several initiatives led by bureaus and programs outside of the OHE also aim to improve minority health. These include the Best Chance Network, the Minority Aids Initiative, and chronic disease prevention initiatives. The Best Chance Network, led by the Division of Cancer Prevention and Control, is a breast cancer and cervical cancer early detection program that provides free screenings for eligible women in South Carolina.[3] Program activities include targeted outreach and education to improve screening rates among African American and Native American women. The STD/HIV Division's Minority AIDS Initiative aims to increase participation of minority populations in the Aids Drug Assistance Program, as well as boost engagement of minority populations in HIV/AIDS medical care and treatment services. The Bureau of Community Health and Chronic Disease Prevention is working to address

3 "Best Chance Network: South Carolina's Breast and Cervical Cancer Early Detection Program." South Carolina Department of Health and Environmental Control. Available on the DHEC website. Last accessed 8/4/2017.

disparities in chronic diseases. For example, the Bureau is implementing targeted obesity prevention efforts in five South Carolina counties with high rates of disparities in obesity prevalence in minority populations. The Bureau is working to increase access to healthy food and physical activity opportunities in these communities.

### Partnerships

| | |
|---|---|
| Primary collaborators | • University of South Carolina, Institute of Medicine and Public Health<br>• South Carolina Office of Rural Health<br>• South Carolina Birth Outcomes Initiative<br>• Alliance for a Healthier South Carolina<br>• South Carolina Cancer Alliance<br>• Diabetes Advisory Council of South Carolina |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships (e.g., OHE has a contract with the University of South Carolina, Institute of Medicine and Public Health). |

The OHE partners with several organizations to advance health equity in South Carolina. The University of South Carolina, Institute of Medicine and Public Health plays a key role in facilitating conversations around obesity prevention with partners across the state. Working with DHEC, the Institute of Medicine and Public Health supports the implementation of SCaleDown, South Carolina's statewide obesity action plan.[4] The OHE also works closely with the South Carolina Office of Rural Health on access to health care and related issues, including development of a state plan for rural health.

The OHE has an ongoing collaboration with the Birth Outcomes Initiative, a collaborative comprised of various organizations and state agencies. As part of the broader initiative aimed at improving birth outcomes, the OHE focuses on birth outcome disparities through its role on the initiative's health disparities committee. The Alliance for a Healthier South Carolina is another significant partner for the OHE. Made up of executive leaders from various organizations across the state, the alliance focuses on improving the health of all South Carolinians.[5] OHE staff are members of the alliance's Health Equity Acceleration Team, which is working to advance health equity.

The South Carolina Cancer Alliance has a health equity workgroup that aims to eliminate cancer disparities. Workgroup activities focus on identifying and addressing the needs of priority populations. A DHEC staff member who is a member of the South Carolina Cancer Alliance implements cancer-prevention activities in communities. To improve equity with regard to diabetes, the OHE participates in the Diabetes Advisory Council of South Carolina. The OHE and the South Carolina Commission for Minority Affairs provide technical assistance and consultation to the council to ensure program plans take into account health equity.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $220,538 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $220,538 |
| Largest funding source | State government |
| Anticipated changes to budget | Unknown |

Funding for minority health and health equity initiatives is included in overall DHEC funding. For FY 2015, $220,538 supported the salaries for the OHE's three full-time staff members. Federal funding specific to minority health was not available to the OHE in FY 2015; funding to address state health disparities was embedded in federal grants with a broader scope. The OHE did not provide funding to organizations to carry out health disparities work in FY 2015. Changes to the sources or amount of funding for health equity activities over the next 2 years is uncertain.

4 "SCale Down" website. Available on the South Carolina Institute of Medicine and Public Health website. Last accessed 8/4/2017.
5 Alliance for a Healthier South Carolina: About Us. Available at the Healthier SC website. Last accessed 8/4/2017.

# South Carolina

## South Carolina State Data

| Total Population[a]: 4,961,119 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 5.5 | 94.5 | 67.3 | 27.0 | 0.3 | 1.6 | 3.8 | 100.0 | NA |
| Percent of population medically uninsured[a] | 30.4 | 9.0 | 9.2 | 11.2 | 13.5 | 11.4 | 21.2 | 10.2 | 10.2 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 7.1 | 4.8 | 11.3 | SP | SP | NC | 6.9 | 5.9 |
| Age-adjusted mortality rate[b] | 357.8 | 841.6 | 802.1 | 939.3 | 352.4 | 386.2 | NC | 829.8 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 12.6 | 13.4 | 12.9 | 15.4 | 9.5 | 2.0 | 14.9 | 13.5 | 13.6 |
| Percent with diabetes[c] | 3.8 | 13.1 | 11.7 | 16.7 | 20.8 | 5.7 | 10.0 | 13.0 | 10.8 |
| Percent with heart disease[c] | 0.9 | 4.6 | 5.3 | 3.3 | 3.6 | 0.0 | 2.8 | 4.6 | 4.3 |
| HIV rate[d] | 393.3 | NC | 143.7 | 1024.2 | 78.0 | 56.3** | 790.3 | 394.6 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 60.9 | 69.2 | 67.0 | 74.3 | 63.7 | 56.0 | 63.7 | 68.7 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 55.1 | 61.2 | 64.2 | 52.3 | 50.0 | 70.8 | 50.5 | 60.6 | 66.5 |
| Percent received flu vaccine[c] | 25.1 | 38.6 | 41.6 | 31.0 | 34.8 | 31.0 | 23.1 | 38.2 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

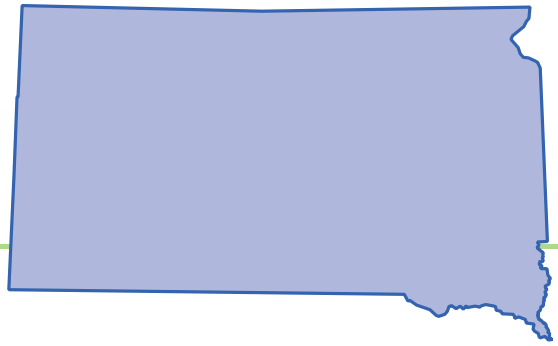
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 56.3 per 100,000 population (35 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 135.6 per 100,000 population (3 cases).

# South Dakota



## Introduction to South Dakota's Health Equity Activities

South Dakota had an estimated 2016 population of 865,000. American Indians/Native Americans are the largest racial-ethnic minority population (9 percent), followed by Hispanics/Latinos (4 percent) and Black/African American (2 percent). Persons self-identifying as multiracial or "other race" comprise 3 percent of the population.[1] Approximately 36 percent of South Dakota's population resides within a health professional shortage area.[2]

One of the least densely populated states in the nation, South Dakota is comprised of mostly rural or frontier areas. With many residents living 60 or more miles from a health care facility and only one city/county health department in the entire state, the South Dakota Department of Health (DOH) relies heavily on statewide cooperative extension services and community-based agencies to improve access to care. It also collaborates extensively with tribal entities to share data and information. The South Dakota Office of Tribal Relations also facilitates communication and collaboration between the state and tribal entities, and the Division of Health and Medical Services (DHMS) targets services and tailors programs to reach immigrant and refugee groups, which are also among the state's priority populations.

### South Dakota Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | N/A |
| Strategic plan in place to address minority health or health equity | A strategic plan specifically to address minority health or health equity does not exist. |
| Date strategic plan was last updated | However, one goal in the Department of Health strategic plan is to improve access to care and quality of care for everyone in South Dakota. |
| Assessment plan in place to measure progress toward reducing health disparities | The Department of Health strategic plan is being developed. |
| Key strategies used to achieve health equity | • Partnering with tribal entities to improve health of Native Americans<br>• Improving access to care in rural communities |

## Organizational Structure

South Dakota does not have an office solely dedicated to minority health, health disparity, or health equity issues. Instead, activities that advance health equity are embedded in initiatives sponsored by the various offices comprising the DOH's Division of Health and Medical Services (DHMS)—e.g., the Office of Chronic Disease Prevention and Health Promotion, the Office of Infectious Diseases, and the Office of Family and Community Health. Because such activities are embedded in ongoing work activities for most DHMS employees, staffing allocations for health equity work is difficult to tease apart from other staffing needs. Mid-level staff with the state DOH commit a large portion of their time to specific initiatives (e.g., the tobacco disparity coordinator), but no senior staff are exclusively dedicated to health equity and minority health initiatives. However, the DOH uses volunteers for some health equity activities (e.g., the coalition affiliated with the Office of Chronic Disease Prevention and Health Promotion are volunteers). The state DOH

1 American Community Survey Public Use Microdata, 2016.
2 Health Services and Resources Administration, Year 2015 population HPSA estimates by state.

also employs paid interns, most of whom are college students who work during the summer.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | No entity is solely responsible for minority health, health disparities, and health equity in South Dakota |
| SMHE staffing (full-time equivalents) | N/A |
| Advisory committee or panel | None |

## Program Goals and Activities

The South Dakota DOH is developing its first formal strategic plan. Its anticipated goals include improving quality, accessibility, and effective use of health care for all South Dakotans. Specific offices within the DOH have developed action plans, and these include references to minority or disparate populations. These action plans integrate objectives related to minority health, health disparities, and health equity. In particular, emphasis is placed on initiatives for American Indian populations.

Many DOH initiatives focus on reducing health disparities affecting its American Indian population. For example, the South Dakota DOH has prioritized tobacco-related activities and is working with tribal partners to establish smoke-free policies in public places on tribal lands. It is also working to create direct referrals from the Indian Health Service's electronic health records to the South Dakota "Quit Line," and to implement other targeted screening and prevention efforts. Other activities that address minority health, health disparities, and health equity are embedded in the department's broader initiatives. For example, the state's DOH is tailoring approaches specifically for foreign-born, low-income, and rural populations to improve access to care.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| South Dakota Department of Health | DOH |
| DOH's Division of Health and Medical Services | DHMS |

The DOH prioritizes activities based on needs identified through surveillance and other data collection efforts. Tribal entities play a role in strategic planning; tribal entities and the State DOH have a mutual goal to enhance and coordinate—and not duplicate—services for American Indian populations.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Tribal entities, including the Northern Plains Indian Health Service<br>• Social service agencies, including the South Dakota Department of Social Services<br>• Cooperative Extension<br>• Community health care association and community health centers<br>• Office of Rural Health |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships (e.g., data sharing agreements). |

South Dakota's DOH partners with tribal entities across the state, including the Northern Plains Indian Health Service and tribal epidemiology centers. Key partnership activities include data sharing with tribal epidemiology centers and regular communication with tribal health entities about emerging disease trends across the state.

Other significant partners include a community health care collaborative, community-based social service agencies, and the Statewide Cooperative Extension. South Dakota's DOH works with these agencies to improve the health of rural, low-income, and immigrant populations. In addition, the department collaborates with the Sioux Falls City Health Department, which is the only city/county health department in the state. The Cooperative Extension is critical in expanding the reach of services to underserved, rural areas of the state where the department's activities normally do not reach. The Office of Rural Health and the Department of Social Services also collaborate on initiatives that involve minority health and health equity.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | No separate SMHE and no specific budget designated for minority health, health disparities, or health equity |
| Annual budget (FY 2015) of SMHE from state/territorial government | |
| Largest funding source | |
| Anticipated changes to budget | |

In South Dakota, funding is not tied specifically to advance minority health, health disparities, or health equity initiatives. Rather, many of the activities that address health disparities are embedded in larger initiatives administered by state DOH. The department's FY 2015 budget was $91,329,147, of which $7,925,518 came from the state general funds, $43,291,140 came from federal funds, and $40,112,489 came from other funds. Two of the offices that administer a significant number of activities aimed at reducing health disparities are the Office of Chronic Disease Prevention and Health Promotion and the Office of Infectious Disease, both of which are almost entirely funded by the federal government. South Dakota receives grants for American Indian health; the amount of money applied toward other disparate populations is unclear.

# South Dakota

## South Dakota State Data

| Total Population[a]: 865,454 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 3.7 | 96.3 | 84.9 | 1.5 | 9.3 | 1.5 | 2.8 | 100.0 | NA |
| Percent of population medically uninsured[a] | 17.5 | 8.3 | 5.8 | 20.0 | 31.1 | 5.6 | 13.8 | 8.6 | 10.2 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 7.3 | 5.9 | SP | 12.5 | SP | NC | 7.3 | 5.9 |
| Age-adjusted mortality rate[b] | 358.7 | 724.3 | 678.1 | 322.9 | 1386.9 | 451.3 | NC | 719.5 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 18.8 | 9.0 | 8.8 | 5.0 | 13.1 | SP | 16.7 | 9.3 | 13.6 |
| Percent with diabetes[c] | 4.7 | 8.0 | 7.9 | 1.5 | 11.8 | SP | 8.9 | 8.0 | 10.8 |
| Percent with heart disease[c] | 4.3 | 4.9 | 5.2 | 1.1 | 4.6 | SP | 2.2 | 4.9 | 4.3 |
| HIV rate[d] | 146.2 | NC | 45.8 | 1017.3 | 150.7 | 42.1** | 119.0 | 73.3 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 57.0 | 70.3 | 71.3 | 80.8 | 60.8 | SP | 46.5 | 70.0 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 58.6 | 71.0 | 72.3 | 75.6 | 53.6 | SP | 51.0 | 70.6 | 66.5 |
| Percent received flu vaccine[c] | 33.3 | 48.7 | 49.5 | 34.8 | 47.6 | SP | 27.4 | 48.4 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

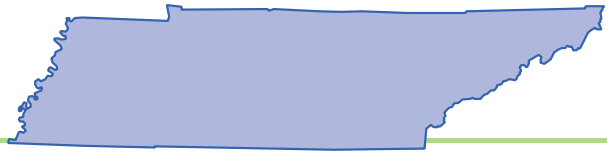
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 42.1 per 100,000 population (4 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 0.0 per 100,000 population (0 cases).

# Tennessee



## Introduction to Tennessee's Health Equity Activities

Tennessee had an estimated 2016 population of 6,651,000. Blacks/African Americans are the largest racial-ethnic minority population (17 percent), followed by Hispanics/Latinos (5 percent), Asian Americans and NHOPI (2 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 3 percent of the population.[1] Approximately 2,449,000 Tennessee residents live within a primary care health professional shortage area.[2]

Created to address the health of minority populations in Tennessee, the Office of Minority Health and Disparities Elimination (OMHDE) works to advance health equity and include social determinants of health in public health strategies. Its mission is to "promote health policies, programs, and services designed to improve health and quality of life by preventing and controlling the disproportionate burden of disease, injury, and disability among racial and ethnic minority populations."[3] It also provides subject matter expertise to programs across the Tennessee Department of Health (DOH). The Office of Rural Health (ORH) is closely connected with the OMHDE and contributes to disparity elimination efforts.

### Tennessee Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Minority Health and Disparities Elimination |
| Strategic plan in place to address minority health or health equity | The Office of Minority Health and Disparities Elimination has a stand-alone strategic plan that serves as an internal resource. |
| Date strategic plan was last updated | The strategic plan is updated periodically. |
| Assessment plan in place to measure progress toward reducing health disparities | No |
| Key strategies used to achieve health equity | • Introducing the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care<br>• Offering small grant opportunities to address health disparities<br>• Providing subject matter expertise to efforts across the Tennessee Department of Health<br>• Championing inclusion of social determinants of health in public health strategies<br>• Increasing the visibility of the Office of Minority Health and Disparities Elimination |

## Organizational Structure

Housed within the DOH Office of the Deputy Commissioner for Population Health, the OMHDE is closely linked to the ORH. Although the OMHDE does not have a formal advisory committee or panel, the Tennessee Black Caucus of State Legislators may discuss priorities and activities with OMHDE staff.

The OMHDE has five full-time staff members, each of whom dedicates 100 percent time to minority health and disparity elimination. Staffing includes the director of the OMHDE, a director of capacity building, a director of faith-based and community initiatives, a Hispanic community engagement coordinator, and an administrative assistant. Additionally, the ORH has six staff members who dedicate at least 25 percent time to minority health initiatives.

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.
3 Information is available on the Tennessee Department of Health's website. Last accessed 10/15/2017.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Office of Minority Health and Disparities Elimination is housed within the Office of the Deputy Commissioner for Population Health. |
| SMHE staffing (full-time equivalents) | 5 |
| Advisory committee or panel | None |

## Program Goals and Activities

The OMHDE's strategic plan, which is updated periodically, serves as an internal tool guiding the office's disparities-related priorities and activities. Although no official assessment plan is in place, the OMHDE informally monitors health outcome data to assess how DOH and OMHDE programmatic efforts affect the health of minority populations. The annually-updated DOH-wide *Tennessee State Health Plan* includes strategies for improving population health with a focus on four key drivers of health status: excessive caloric intake, tobacco and nicotine use, physical inactivity, and substance use disorders. During its development and subsequent updates, the DOH's Division of Health Planning solicited public input and engaged key stakeholders to enhance its understanding of health issues across the state. The DOH also maintains a closely aligned, department-wide strategic plan, and is exploring how to incorporate social determinants of health into future planning efforts.

Efforts to educate DOH's section leaders and others about the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) fall within the purview of the OMHDE. In addition to assessing DOH leadership's familiarity with the National CLAS Standards, the OMHDE has been documenting complementary section activities and plans to share results of its data collection and subsequent analysis with the leadership team.

Recognizing the disproportionate effects of violence on minority health, the OMHDE is spearheading efforts to bring attention to the issue as a public health concern. Staff with the OMHDE have been initiating conversations with community partners, law enforcement entities, and other state agencies to better understand drivers and inhibitors of violence; they are also documenting strategies implemented across the state to reduce its prevalence. Additionally, the OMHDE is exploring how to improve sources of violence data in Tennessee. The OMHDE plans to convene stakeholders from five hotspot counties to ascertain the range of anti-violence strategies such communities currently employ and will seek feedback on how the OMHDE can support violence-reduction efforts.

To ensure that the health needs of racial and ethnic minority populations are adequately included across the DOH's public health activities, the OMHDE's staff serve as a department-wide program planning resource by contributing minority health subject matter expertise on public health activities. For example, the OMHDE worked with the Office of Communicable and Environmental Diseases and Emergency Preparedness to identify culturally responsible language to share for vulnerable and immigrant populations around Zika virus prevention and control. The OMHDE also organizes community engagement efforts, promotes the disaggregation of data to more precisely identify disparities affecting population subgroups, and raises awareness about the social determinants of health within the DOH. As the only state government agency exclusively focusing on racial and ethnic minority populations, the OMHDE also works to increase its visibility throughout state government.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Office of Minority Health and Disparities Elimination | OMHDE |
| Office of Rural Health | ORH |
| Department of Health | DOH |

Efforts to reduce health disparities in rural regions of the state also fall within the purview of the ORH. For example, the ORH developed and distributes a rural-urban fact sheet, which includes racially disaggregated health outcomes data. The ORH also identifies health professional shortage areas and helps address issues with access to health care.

# Tennessee

### Partnerships

| | |
|---|---|
| Primary collaborators | • Community-based and faith-based organizations<br>• Historically Black colleges and universities<br>• Knox County Health Department, Metro Public Health Department, Shelby County Health Department<br>• Memphis Breast Cancer Consortium |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

The OMHDE partners with many organizations to reduce health disparities and improve minority health. It offers competitive funding opportunities to community-based and faith-based organizations and has distributed more than 30 small ($10,000) awards to organizations across the state. The Memphis Breast Cancer Consortium, for example, received OMHDE funding to provide African American women across the state with information about breast cancer prevention. Per the state's new funding requirements, eligible activities must specifically address issues related to both social determinants of health and DOH-determined priority health outcomes. Local health departments can also receive small ($2,500) OMHDE grants to address health disparities through primary prevention efforts. The OMHDE also works with local health departments (e.g., those in Knox and Shelby counties and the Metro Public Health Department) to share information, resources, and facilitate connections with community-based and faith-based organizations.

Tennessee's five historically Black colleges and universities are frequent partners of the OMHDE which, for example, has awarded $40,000 to each of these institutions to address at least one DOH health priority on its campus. Initiatives must be student-driven and supported by faculty and staff, providing an opportunity to engage young African Americans and enhance the health sciences career pipeline.

To improve access to care and reduce disparities in rural regions of the state, the ORH partners with the Tennessee Hospital Association to place needed providers in health professional shortage areas. The ORH also partners with the Tennessee Primary Care Network, a network of safety net clinics funded by the DOH, to conduct trainings and disseminate educational materials.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $1,360,700 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $1,360,700 |
| Largest funding source | State government |
| Anticipated changes to budget | Unknown |

The FY 2015 OMHDE budget of $1,360,700 was entirely comprised of state funding. State allocations have been relatively consistent at this level for 4 years. In FY 2015, the OMHDE awarded 30 grants of $5,000 to community-based and faith-based organizations to support health disparities elimination activities in local communities. The OMHDE also provided funding to local health departments to address health disparities.

In FY 2015, the ORH received state funding to support safety net clinics ($12,000,000) and funding from the State Loan Repayment Program ($315,000), with matching funds from the U.S. Health Resources and Services Administration ($315,000). The ORH provided funding to federally qualified health centers ($6,000,000) and faith-based and charitable care organizations ($6,000,000), and provided funding to support health care professionals through the State Loan Repayment Program.

# Tennessee

## Tennessee State Data

| Total Population[a]: 6,651,194 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 5.2 | 94.8 | 78.0 | 16.7 | 0.3 | 1.9 | 3.2 | 100.0 | NA |
| Percent of population medically uninsured[a] | 31.4 | 8.2 | 8.7 | 10.8 | 16.6 | 9.6 | 17.5 | 9.4 | 10.2 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 5.0 | 7.0 | 6.0 | 10.4 | SP | SP | NC | 7.0 | 5.9 |
| Age-adjusted mortality rate[b] | 351.9 | 895.4 | 877.7 | 981.7 | 257.8 | 392.4 | NC | 886.3 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 16.0 | 15.9 | 15.8 | 18.2 | 12.7 | 8.5 | 19.7 | 16.2 | 13.6 |
| Percent with diabetes[c] | 8.4 | 12.9 | 13.0 | 11.8 | 15.3 | 12.9 | 12.3 | 12.8 | 10.8 |
| Percent with heart disease[c] | 2.6 | 5.5 | 6.0 | 2.8 | 10.6 | 5.0 | 2.5 | 5.4 | 4.3 |
| HIV rate[d] | 353.4 | NC | 139.3 | 1016.3 | 64.1 | 69.8** | 782.0 | 297.4 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 56.0 | 71.3 | 70.1 | 75.8 | 58.1 | 78.8 | 52.9 | 70.6 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 51.9 | 59.8 | 61.1 | 54.7 | 32.2 | 67.4 | 45.5 | 59.4 | 66.5 |
| Percent received flu vaccine[c] | 23.6 | 37.0 | 38.7 | 26.1 | 53.8 | 49.0 | 25.1 | 36.7 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

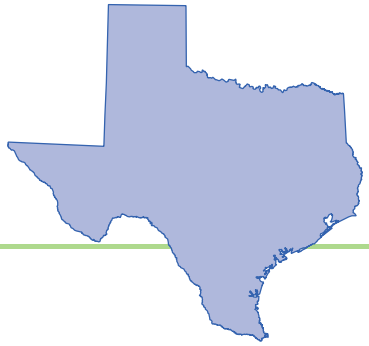
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 69.8 per 100,000 population (65 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 260.2 per 100,000 population (7 cases).

# Texas



## Introduction to Texas' Health Equity Activities

Texas had an estimated 2016 population of 27,863,000. Hispanics/Latinos are the largest racial-ethnic minority population (39 percent), followed by Blacks/African Americans (12 percent), Asian Americans and NHOPI (5 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 8 percent of the population.[1] Approximately 5,729,000 Texas residents live within a primary care health professional shortage area.[2]

The Texas Office of Minority Health was established in 1993 as a stand-alone entity within what was then the Texas Department of Health. In 2011, it became the Center for Elimination of Disproportionality and Disparities (CEDD) within the Texas Health and Human Services Commission (THHSC). The CEDD, which is the state's minority health entity, includes an Office of Minority Health and Health Equity (OMHHE). The THHSC oversees several state departments responsible for health and human services, and within that structure, the CEDD can readily partner with state agencies. The State Advisory Coalition for Addressing Disproportionality and Disparities addresses related policy and practice changes within the THHSC.

### Texas Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Center for Elimination of Disproportionality and Disparities |
| Strategic plan in place to address minority health or health equity | Health equity priorities are integrated into the Texas Health and Human Services Commission's strategic plan. |
| Date strategic plan was last updated | 2014 |
| Assessment plan in place to measure progress toward reducing health disparities | Yes. The assessment plan is part of the annual operational plan. |
| Key strategies used to achieve health equity | • Education and outreach<br>• Leadership development to build capacity for addressing health inequities<br>• Partnerships and cross-collaboration<br>• Data analysis<br>• Policy and practice |

## Organizational Structure

In support of its mission to eliminate disproportionality and disparities, the CEDD provides oversight to the OMHHE, as well as the Regional Equity Initiatives that involve regional equity specialists throughout Texas. The CEDD has a director and seven mid-level staff who dedicate about 80 percent time to minority health and health equity initiatives. An eighth mid-level staff person contributes about 50 percent time to grant application activities in support of minority health and health equity initiatives. In total, eight staff members contribute at least half their time to minority health activities. Beyond these positions, the CEDD regularly engages unpaid interns to help with minority health activities. As of 2017 there are no concrete plans to increase the number of staff working on minority health and health equity initiatives.

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The CEDD is a center within the Texas Health and Human Services Commission |
| SMHE staffing (full-time equivalents) | 8 |
| Advisory committee or panel | State Advisory Coalition for Addressing Disproportionality and Disparities |

## Program Goals and Activities

Since 2010, health equity strategies have been integrated into the THHSC strategic plan, which covers a period of approximately 5 years and was last updated in 2014. The CEDD's annual operational plan includes an assessment plan to measure progress toward reducing disparities. At the time of data collection, Texas had no stand-alone strategic plan for minority health or health equity.

In setting priorities for minority health, health disparities, and health equity, the CEDD focuses on two factors: 1) the data-driven strategic priorities identified by the State Advisory Coalition for Addressing Disproportionality and Disparities and 2) the U.S. Office of Minority Health's strategic priorities. Partners that are engaged with communities also provide input about priorities.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Texas Health and Human Services Commission | THHSC |
| Center for Elimination of Disproportionality and Disparities | CEDD |
| Office of Minority Health and Health Equity | OMHHE |

The CEDD's disparity reduction strategies focus on revising practices to improve outcomes. Key to practice change is the CEDD's support for health professionals and community members. One support strategy is education and outreach among health professionals and community members. Within the CEDD, the OMHHE leads education and outreach using training modules and presentations on the National Standards for Culturally and Linguistically Appropriate Services (National CLAS Standards), health equity, and social determinants of health at state and local conferences.

The OMHHE has an online training on the CLAS for use by Medicaid-supported organizations, health professionals, and social workers. It also shares presentations on health inequities and social determinants of health to providers and community members. A related CEDD strategy involves building capacity among healthcare professionals and others to help address health inequities by conducting trainings for THHSC employees statewide.

In addition, the Regional Equity Initiative, another element of the CEDD's work, uses "equity specialists" to work in communities across Texas. One equity specialist partners with state and community stakeholders in each of the state's 11 regions. These specialists offer technical assistance and training to local providers and help foster collaborations to eliminate disparities in health as well as other areas (e.g., education and juvenile justice). Equity specialists help identify and analyze data to identify disparities, establish regional advisory committees to help explore underlying causes, and work to support communities in ameliorating inequities.

Cross-agency collaboration with disease- or condition-specific teams throughout the Texas Department of State Health Services and the THHSC is a key strategy the CEDD employs in its efforts to achieve health equity. For example, the CEDD joins efforts with child welfare agencies to achieve infant mortality reduction goals among minority populations. It also works with the Texas Emerging and Acute Infectious Disease Branch to address disparities in HIV/AIDS incidence and prevalence. Since 2014, the CEDD has worked with Texas Medicaid and the Texas Children's Health Insurance Program (CHIP) to adjust cultural competency efforts to mirror the National CLAS Standards. Several of these cross-collaborations serve African Americans and Hispanics in east and south Texas.

Additionally, the CEDD continues to emphasize quality data collection and analysis to help drive policy changes around health disparity elimination. The CEDD has developed a how-to guide for identifying and monitoring reductions in disparities and is analyzing qualitative and quantitative data to inform program modification. It established a data evaluation workgroup in early 2016, which has sought to establish a central data repository so that various health agencies in the state can use consistent data to compare programs and services. The CEDD also has sought to identify relevant THHSC policies and to participate in workgroups responsible for performance metrics.

# Texas

### Partnerships

| | |
|---|---|
| Primary collaborators | • Local health departments<br>• Other state agencies<br>• Universities |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships (e.g., those with several city health departments). |

The CEDD's primary partners are city and county health departments, other state agencies, and universities. For example, it works with local health departments to build capacity, obtain state partnership grants, and refine the public health accreditation process. The CEDD has a memorandum of understanding with three city health departments that are involved in grants primarily directed at efforts to reduce obesity.

Since the state health department is within the same organizational system as the CEDD there is no formal contract in place with the state health department; instead the CEDD has a collaborative partnership agreement with the state health department

The CEDD also works with the Texas Juvenile Justice Department, Texas Medicaid, and Texas CHIP to address health equity issues. For example, the CEDD helps test for HIV/AIDS on behalf of the Texas Juvenile Justice Department. Partnerships with Medicaid and CHIP focus primarily on women's health programs; those agencies have primary responsibility for interacting with clients and communities and the CEDD plays a supporting and guiding role to help the agencies better address health inequity.

State universities, particularly their public health and social work departments, also work closely with the CEDD to explore opportunities for research and to collaborate with internship programs.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | Approximately $600,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | Unknown |
| Largest funding source | Federal Government |
| Anticipated changes to budget | Possibly in 2018, but unknown |

The total FY 2015 funding for the CEDD was approximately $600,000. In FY 2015, the largest single source of funding was a U.S. Office of Minority Health grant (approximately $200,000). The remaining funding (approximately $400,000) came from a mix of state general revenue and other federal and state grants, including a grant from the federal Substance Abuse and Mental Health Services Administration to fund the Texas System of Care. Some funds came from other state agencies through the previously mentioned collaborative partnership agreements. The CEDD provided approximately $110,000 of the U.S. Office of Minority Health grant to city health departments and external evaluators, and approximately $20,000 to universities for health disparities activities in FY 2015. The funds appropriated through the Texas general revenue could change in 2018 with the release of the next legislative rider.

# Texas

## Texas State Data

| Total Population[a]: 27,862,596 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 39.1 | 60.9 | 74.4 | 12.1 | 0.5 | 4.7 | 8.4 | 100.0 | NA |
| Percent of population medically uninsured[a] | 26.8 | 11.0 | 16.9 | 15.4 | 22.6 | 11.0 | 24.7 | 17.2 | 10.2 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 5.3 | 6.0 | 5.2 | 9.9 | SP | 3.7 | NC | 5.7 | 5.9 |
| Age-adjusted mortality rate[b] | 606.2 | 772.3 | 732.1 | 883.1 | 146.6 | 366.7 | NC | 730.6 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 8.7 | 14.7 | 12.7 | 17.8 | 13.2 | 6.5 | 12.9 | 13.1 | 13.6 |
| Percent with diabetes[c] | 12.0 | 10.7 | 10.9 | 14.7 | 16.5 | 7.8 | 4.7 | 11.2 | 10.8 |
| Percent with heart disease[c] | 2.3 | 4.5 | 4.1 | 3.4 | 1.8 | 2.3 | 2.4 | 3.8 | 4.3 |
| HIV rate[d] | 324.3 | NC | 212.8 | 1150.2 | 53.4 | 78.8** | 1279.1 | 368.9 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 62.3 | 73.9 | 69.3 | 79.9 | 64.8 | 68.7 | 73.6 | 70.7 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 54.1 | 64.6 | 61.5 | 64.2 | 55.7 | 65.7 | 54.9 | 61.8 | 66.5 |
| Percent received flu vaccine[c] | 31.9 | 40.7 | 38.7 | 32.9 | 43.4 | 47.6 | 29.8 | 38.2 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

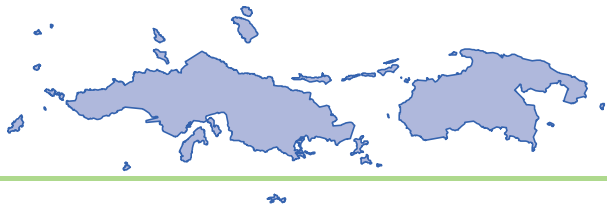
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 78.8 per 100,000 population (810 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 139.5 per 100,000 population (25 cases).

# U.S. Virgin Islands



## Introduction to U.S. Virgin Islands' Health Equity Activities

The U.S. Virgin Islands (USVI) had an estimated 2010 population of 105,000. Blacks/African Americans are the largest racial-ethnic minority population (76 percent), followed by Hispanics/Latinos (17 percent). Persons self-identifying as multiracial or "other race" comprise 2 percent of the population.[1]

Public health, clinical care, and environmental health services fall within the purview of the USVI Department of Health (DOH), which also provides emergency medical response services and functions as the USVI regulatory body for health care providers and facilities. Although a departmental reorganization is in progress, no office within the USVI DOH is dedicated solely to minority health, health disparities, or health equity issues. However, given that most of the USVI's population represents a racial or ethnic minority group, a focus on minority populations is embedded in all DOH programs.

### U.S. Virgin Islands Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | N/A |
| Strategic plan in place to address minority health or health equity | The Department of Health is developing a territorial health strategic plan; an update of the territorial Healthy People plan is also anticipated. |
| Date strategic plan was last updated | *Healthy Virgin Islands 2010* was last updated in 2003. |
| Assessment plan in place to measure progress toward reducing health disparities | An overarching plan to measure progress toward reducing health disparities is not available, but the Department of Health does measure outcomes for selected programs. |
| Key strategies used to achieve health equity | • Health education and outreach<br>• Department of Health staff trainings |

## Organizational Structure

Most of the DOH's approximately 450 staff members spend at least some portion of each day working to improve population health and achieve health equity. For example, DOH staff members focusing on such activities as diabetes prevention, tobacco cessation and prevention, and communicable disease control engage in health equity work, even when it is not explicitly part of the job description. With DOH budget cuts anticipated, the DOH may need to reduce staff size.

| | |
|---|---|
| Location of state/ territorial minority health entity (SMHE) within state/territorial government | The U.S. Virgin Islands Department of Health is one of several departments housed under the Office of the Governor. |
| SMHE staffing (full-time equivalents) | The U.S. Virgin Islands Department of Health has approximately 450 employees, many of whom spend some time supporting population health initiatives. |
| Advisory committee or panel | Plans are in place to establish a public health advisory committee. |

1 American Community Survey Public Use Microdata, 2016.

## Program Goals and Activities

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| U.S. Virgin Islands | USVI |
| Department of Health | DOH |

To garner insights into how best to meet patient needs, staff with the DOH engage in conversations with health care facilities staff to better understand why patients are seeking care. Another strategy to assess needs is to improve the territory's health data infrastructure, which is one of the DOH's current goals. Such improvements, including a transition to electronic vital records, would ensure that the department has access to validated, accurate, and detailed data. An important step towards this objective was the USVI's 2016 participation in the Behavioral Risk Factor Surveillance System. Analyses of the resulting survey data will help guide the DOH's priority setting.

The DOH is working to establish a public health advisory committee to offer the department guidance on priority setting and programmatic activities. On an ad-hoc basis, specific DOH programs engage an advisory committee comprised of nongovernmental stakeholders. Such committees offer guidance on particular issues of interest, such as mental health, substance abuse, chronic disease prevention, and HIV/AIDS. Although the DOH has no overarching territorial strategic plan currently, it is working with a contractor to develop such a blueprint. The resulting plan will focus on public health and health care delivery and will clarify which DOH divisions are responsible for activities of the department, USVI hospitals, and federally qualified health centers (FQHCs). The plan will highlight how health care entities should collaborate to improve health care delivery and overall health. That same contractor will also update the DOH's *Healthy People plan*; its previous iteration, *Healthy Virgin Islands 2010: Improving Health for All*, was last updated in 2003.

A major focus of the DOH is to increase awareness of disease prevention and preventive care, public health issues, and healthy lifestyle behaviors through health-related information dissemination and outreach. In addition to publishing newspaper articles, broadcasting both television- and radio-based public service announcements, and posting information on the DOH website and Facebook pages, the DOH organizes health fairs to provide information, health tests, and immunizations. The DOH also conducts additional outreach efforts on such topics as communicable disease prevention, tobacco cessation, and heart disease management. With support from the U.S. Centers for Disease Control and Prevention and the Association of State and Territorial Health Officials, the USVI will participate in the Million Hearts State Learning Collaborative to reduce the risk of heart attack and stroke through blood pressure monitoring and control.[2]

Building public health capacity through organizational changes and staff trainings has been another priority for the DOH. In 2013–2014, the departure of a major employer in the territory led to a significant reduction in DOH staff size. Since then, the DOH has worked to restore the department's organizational capacity and expertise, enabling it to enhance its programmatic activities. It continues to build capacity around program planning and management, as well as monitoring and evaluation. While the DOH reviews outcomes for selected initiatives, no overarching assessment plan is currently in place to monitor progress toward reducing health disparities.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Federally qualified health centers<br>• Local hospitals<br>• University of the Virgin Islands<br>• U.S. Virgin Islands: Department of Agriculture, Department of Education, Department of Planning and Natural Resources<br>• Women's Coalition of St. Croix |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships. |

The DOH partners with organizations committed to eliminating health disparities and improving the health of the USVI population. For example, two FQHCs are key partners in extending service reach and providing health education within communities. FQHC staff often join DOH staff at health fairs and community events to provide on-site counseling, immunizations, and screening. Dedicated space within the FQHCs allows the DOH to provide services that the FQHC otherwise

2 Association of State and Territorial Health Officials. Heart Disease and Stroke: State Learning Collaborative to Improve Blood Pressure Control. Available on the ASTHO website.

would not be able to provide. In addition, the DOH works with FQHCs in designing and conducting community health surveys.

USVI hospitals also partner with the DOH to improve access to health services. A memorandum of agreement between the DOH and a USVI hospital is in place. Under this agreement, the DOH assists the hospital with its 24-hour mental health hotline.

The University of the Virgin Islands, another prominent partner, leads public health trainings with DOH staff and conducts surveys on specific topics. In 2017, the DOH collaborated with its School of Nursing, as well as the St. Croix campus of Barry University's physician assistant training program, to provide health services free of charge at the USVI's Agricultural Fair.[3]

Several community-based organizations also partner with the DOH. The Women's Coalition of St. Croix, for example, collaborates with the department on sexual assault and domestic violence prevention efforts. In some cases, the DOH provides funding to community-based organizations, which funds salaries of community workers that implement specific health initiatives.

Examples of territorial government agencies with which the DOH partners include the USVI Department of Agriculture, which oversees the Special Supplemental Nutrition Program for Women, Infants, and Children. Through this partnership the two departments distribute vouchers, redeemable for fresh fruits and vegetables, to low-income individuals. They also collaborate on efforts to engage farmers about public health laws governing agricultural activities, as well as to improve the distribution of fresh fruits and vegetables and to educate community members on the importance of eating fresh fruits and vegetables.

In partnership with the USVI Department of Education, the DOH embarked on joint efforts to secure school-based health education programs, as well as school food service program regulations. The DOH also collaborates with the USVI Department of Planning and Natural Resources to disseminate information about water and beach safety to the public.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | The DOH receives approximately $15,000,000–$20,000,000 for a broad range of activities that advance health equity. |
| Annual budget (FY 2015) of SMHE from state/territorial government | N/A |
| Largest funding source | Federal government |
| Anticipated changes to budget | Possible budget cuts |

The total FY 2015 funding for the DOH to support operations and service delivery was approximately $50,000,000, with roughly 30–40 percent of funding contributing to activities that help advance health equity in the USVI. Approximately $30,000,000 of the overall FY 2015 DOH funding came from federal sources. Most federal grants are ongoing, but the DOH anticipates cessation of funding for addressing the Zika virus and additional budget cuts in the coming years.

3 United States Virgin Islands Department of Health. DOH to Provide Free Services at Agriculture Fair. Available on the DOH website.

# U.S. Virgin Islands

## U.S. Virgin Islands Terrirtory Data

| Total Population[a]: 27,862,596 | Ethnicity | | Race | | | | Totals | |
|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | Multiracial | Other | Territory Total | National Total |
| **Population Characteristics** | | | | | | | | |
| Percent of state population[a] | 17.4 | 82.6 | 15.6 | 76.0 | 2.1 | 6.2 | 100.0 | NA |
| Percent of population medically uninsured[a] | 41.5 | 28.6 | 28.2 | 30.9 | 32.9 | 35.5 | 30.8 | 16.3[b] |

| Total Population[a]: 27,862,596 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian or Pacific Islander | Multiracial or Other | Territory Total | National Total |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | NC | NC | NC | NC | NC | NC | SP | 5.9 |
| Age-adjusted mortality rate[b] | NC | NC | NC | NC | NC | NC | NC | 531.0 | 733.1 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 18.0 | 8.8 | 12.5 | 10.1 | SP | 8.6 | SP | 10.4 | 13.6 |
| Percent with diabetes[c] | 9.5 | 13.2 | 6.3 | 13.5 | SP | 24.0 | SP | 12.8 | 10.8 |
| Percent with heart disease[c] | 0.4 | 2.3 | 6.3 | 1.6 | SP | 0.0 | SP | 2.0 | 4.3 |
| HIV rate[d] | SP | NC | SP | SP | SP | SP | SP | 635.5 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 53.4 | 72.0 | 60.7 | 69.8 | SP | 77.6 | SP | 69.2 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 44.8 | 52.9 | 48.9 | 52.3 | SP | 50.6 | SP | 51.4 | 66.5 |
| Percent received flu vaccine[c] | 13.0 | 15.9 | 22.8 | 13.6 | SP | 23.4 | SP | 15.6 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: U.S. Census Bureau. 2010 Census Island Areas: 2010 Census Detailed Crosstabulations.

b Source: U.S. Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States: 2010

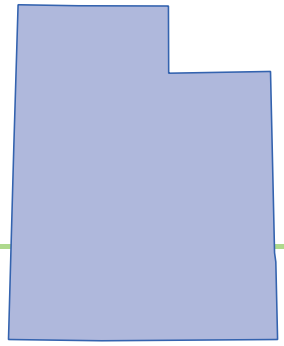
c Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015.

d Source: CDC National Vital Statistics Reports, Deaths: Final Data for 2015.

e Source: Behavioral Risk Factor Surveillance System, 2016.

f Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015

# Utah



## Introduction to Utah's Health Equity Activities

Utah had an estimated 2016 population of 3,051,000. Hispanics/Latinos are the largest racial-ethnic minority population (14 percent), followed by Asians/Pacific Islanders (3 percent), Blacks/African Americans (1 percent), and American Indians/Alaska Natives (1 percent). Persons self-identifying as multiracial or "other race" comprise 8 percent of the population.[1] Approximately 747,000 Utah residents live within a primary care health professional shortage area.[2]

The Office of Health Disparities (OHD) replaced the Center for Multicultural Health during the 2011 legislative session, in compliance with Senate Bill 33. While the center focused on coordinating efforts to address racial and ethnic health disparities, the OHD has a broader mission of reducing disparities by geography and income as well as by race and ethnicity. At the end of 2016, the OHD began reporting directly to the Utah Department of Health (UDOH) Deputy Director (previously it had reported to the Division of Family Health and Preparedness). The OHD also coordinates a Health Disparities Advisory Council, which consists of community partners and other agencies that work with racial and ethnic minorities.

### Utah Minority Health Overview

| | |
|---|---|
| Name of state/territorial minority health entity | Utah Office of Health Disparities |
| Strategic plan in place to address minority health or health equity | The strategic plan has expired; a new strategic plan with health disparities integrated into the broader health department plan is under development. It will be released in December 2017. |
| Date strategic plan was last updated | The strategic plan was being updated at the time of the data collection for this report. The stand-alone OHD plan, last updated in 2013, covered 2013–2015; the Department-wide plan covered 2013–2016. |
| Assessment plan in place to measure progress toward reducing health disparities | Yes |
| Key strategies used to achieve health equity | • Promoting access to primary care among underserved communities<br>• Promoting access to dental care among underserved communities<br>• Reducing adverse birth outcomes among Pacific Islanders<br>• Promoting National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care<br>• Increasing awareness of health disparities through data reports |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

## Organizational Structure

The OHD has functioned in its current role since 2011. It was established to reduce racial and ethnic disparities, but also seeks out opportunities to address health disparities by geography and income. Three full-time staff members, including the OHD director and two program specialists, dedicate all of their time to minority health, health disparities, and health equity initiatives. Eight interns support them, though they each spend less than half of their time on such initiatives. Other staffing assistance includes approximately five individuals who work for either the UDOH Family Dental Plan or the UDOH Oral Health Program, and three to five volunteers from the University of Utah who spend between 5 and 10 percent of their time on OHD strategic initiatives. A part-time employee may also be hired.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The OHD is at the department level of the Utah Department of Health; reports directly to the Deputy Director |
| SMHE staffing (full-time equivalents) | 3 |
| Advisory committee or panel | Health Disparities Advisory Council |

## Program Goals and Activities

Utah has maintained a strategic plan addressing health disparities since 2008. The OHD is transitioning from a stand-alone strategic plan for health disparities alone to one that is integrated into the broader UDOH strategic plan. The stand-alone strategic plan has been updated every 3 to 5 years; the latest version covered 2013–2015. The most recent department-wide strategic plan spanned 2017–2020. An evaluation plan also is in place for activities, including those related to federal grant awards, that the OHD oversees.

Funding sources and data are the primary factors driving the selection of minority health, health disparities, and health equity goals. Some goals reflect priorities associated with federal funding, as well as priorities mandated by the Utah legislature. Other goals have emerged from working with the UDOH Center for Health Data to examine primary data collected from the community (obtained in part from assessments performed with nongovernment partners) and secondary data from public health databases.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Utah Department of Health | UDOH |
| Office of Health Disparities | OHD |

The OHD is working on many strategies to achieve health equity and eliminate health disparities. Two strategies aim to promote access to primary care and dental care among underserved communities. The OHD is collaborating with multiple partners, including the state Medicaid program and community health centers, to focus on two geographic areas (the neighborhood of Glendale and the City of South Salt Lake) with a high proportion of medically underserved individuals, most of whom are racial and ethnic minorities. Community partners conduct outreach and identify individuals in need, while UDOH agencies conduct screenings and refer individuals to primary care services. Another strategy focuses on promoting the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) at medical and dental clinics within these two communities. Specifically, the OHD assessed providers' level of knowledge about the National CLAS Standards and then developed online trainings to increase awareness among providers throughout the state who serve patients with limited English proficiency. In addition, the OHD is in the process of piloting evidence-based methods to reduce adverse birth outcomes among Pacific Islanders and Hawaiian Natives by developing a culturally appropriate educational program. It also has in place a strategy to increase awareness of health disparities by publishing data analyses and reports on such topics as health status by race and ethnicity, health disparity trends among racial and ethnic minorities, and the top 15 languages spoken in local health districts and counties.

# Utah

### Partnerships

| | |
|---|---|
| Primary collaborators | • Federal Office of Minority Health<br>• City of South Salt Lake<br>• Salt Lake County Health Department<br>• UDOH Family Dental Plan<br>• UDOH Oral Health Program<br>• UDOH Bureau of Maternal and Child Health<br>• UDOH Bureau of Health Promotion<br>• UDOH Medicaid Program<br>• UDOH Media Relations<br>• Utah Health Policy Project<br>• Communities United<br>• Association for Utah Community Health, Community Health Centers<br>• Community Building Community<br>• National Tongan American Society<br>• Somali Community Self-Management Agency<br>• Queen Center<br>• University of Utah School of Dentistry Residency Program<br>• Fortis College Dental Hygienist Training Program<br>• Latter-day Saint Humanitarian Center<br>• UDOH Utah Indian Health Advisory Board |
| Contracts or memoranda of understanding with any partners | Contracts are in place with all partners that receive funding from the OHD. This includes:<br>• UDOH Family Dental Plan<br>• UDOH Office of Public Information and Marketing<br>• Utah Health Policy Project<br>• Communities United<br>• Association for Utah Community Health, Community Health Centers<br>• Community Building Community<br>• National Tongan American Society<br>• Somali Community Self-Management Agency<br>• Queen Center |

The OHD partners with several government organizations at the federal, state, county, and city levels, as well as with nongovernment organizations, academic institutions, faith-based organizations, and a community board. It puts in place contracts to manage funding provided to or received from partners. Contracts are currently in place with nongovernment partners, as well as partners at the state government level that receive OHD funding. Most of the initiatives covered by such contracts address the OHD's strategies promoting access to primary or dental care among underserved communities and reducing adverse birth outcomes among Pacific Islanders.

In addition to these contractual arrangements, the OHD has informal agreements with local governments, academic institutions, a faith-based organization, and a community board. These informal partnerships are not always tied to specific initiatives and strategies, but help the OHD address minority health more broadly. Among public health institutions is the UDOH Oral Health Program, which conducts training related to promoting access to dental care among underserved communities. The Latter-Day Saint Humanitarian Center, meanwhile, assists the OHD with outreach among refugee populations, while the Health Access Project assists OHD's targeted communities to establish medical homes. The OHD also collaborates closely with other UDOH programs such as the Family Dental Plan and the UDOH American Indian Liaison.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $384,500 |
| Annual budget (FY 2015) of SMHE from state/territorial government | $163,500 |
| Largest funding source | Federal grant from federal Office of Minority Health |
| Anticipated changes to budget | Possible (as reported at the time of data gathering) |

Total FY 2015 funding for the OHD was $384,500. In FY 2015, it had three key funding sources: a grant from the federal Office of Minority Health ($175,000), Utah general revenue funding ($163,500), and a federal Maternal and Child Health Block Grant ($46,000). Awarded in FY 2015, the Maternal and Child Health Block Grant funded an initiative to reduce adverse birth outcomes disparities among Pacific Islanders; the other two sources of funding are ongoing. In turn, the OHD provided $97,000 to other organizations in FY 2015, including six nongovernment partner agencies ($75,000), a private entity for social interactive video development ($18,000), and the Utah Government Office of Marketing and Media ($4,000).

# Utah

## Utah State Data

| Total Population[a]: 3,051,217 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 13.8 | 86.2 | 86.5 | 1.1 | 1.0 | 3.4 | 8.1 | 100.0 | NA |
| Percent of population medically uninsured[a] | 22.0 | 6.7 | 7.5 | 7.1 | 25.2 | 10.4 | 20.3 | 8.8 | 10.2 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 5.5 | 4.9 | 5.0 | SP | SP | SP | NC | 5.0 | 5.9 |
| Age-adjusted mortality rate[b] | 548.1 | 725.1 | 719.9 | 672.3 | 701.7 | 515.1 | NC | 730.6 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 9.9 | 14.4 | 14.1 | 27.3 | 9.9 | 7.9 | 17.9 | 14.1 | 13.6 |
| Percent with diabetes[c] | 6.2 | 7.4 | 7.1 | 9.0 | 16.0 | 6.4 | 6.4 | 7.2 | 10.8 |
| Percent with heart disease[c] | 1.6 | 2.6 | 2.6 | 0.0 | 3.3 | 1.6 | 0.7 | 2.4 | 4.3 |
| HIV rate[d] | 201.1 | NC | 92.7 | 1028.3 | 100.8 | 95.4** | 164.7 | 116.4 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 60.5 | 62.7 | 62.7 | 55.0 | 62.5 | 63.2 | 61.5 | 62.6 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 63.5 | 74.9 | 74.9 | 67.1 | 47.0 | 65.9 | 62.3 | 73.6 | 66.5 |
| Percent received flu vaccine[c] | 27.7 | 37.4 | 37.2 | 19.7 | 35.5 | 33.5 | 30.2 | 36.6 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

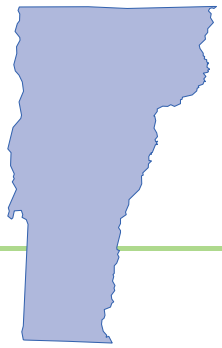
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 95.4 per 100,000 population (56 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 23.7 per 100,000 population (5 cases).

# Vermont



## Introduction to Vermont's Health Equity Activities

Vermont had an estimated 2016 population of 625,000. The largest racial-ethnic minority populations are Hispanics/Latinos (2 percent), followed by Asian Americans and NHOPI (1 percent), Blacks/African Americans (1 percent), and American Indians/Alaska Natives (1 percent). Persons self-identifying as multiracial or "other race" comprise 3 percent of the population.[1] Approximately 12,000 Vermont residents live within a primary care health professional shortage area.[2]

The Office of Health Equity (OHE) is located within the Vermont Department of Health (VDOH). Both the OHE and the VDOH seek to improve health equity by addressing avoidable inequalities, particularly for those who have experienced socioeconomic disadvantage and social injustice.[3] Because all offices and programs within the VDOH share a responsibility to address health equity, the OHE collaborates with other VDOH divisions.

### Vermont Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Health Equity |
| Strategic plan in place to address minority health or health equity | *The Vermont Department of Health Strategic Plan 2014-2018*[4] identifies health equity as a strategic goal. |
| Date strategic plan was last updated | 2016 |
| Assessment plan in place to measure progress toward reducing health disparities | The Office of Health Equity monitors progress through the Social Determinants of Health/ Health Equity Scorecard.[5] |
| Key strategies used to achieve health equity | • Collecting diversity data<br>• Building community partnerships<br>• Fostering cultural competence throughout the Vermont Department of Health |

## Organizational Structure

Located within the planning unit of the VDOH Commissioner's Office, the OHE does not have a committee or panel advising on minority health or health equity issues. The OHE's director, its only staff member, dedicates half of her time to disparity reduction initiatives. However, because the topic is an overarching VDOH priority, staff throughout the department dedicate time to advancing health equity.

| | |
|---|---|
| Location of state/ territorial minority health entity (SMHE) within state/territorial government | The OHE is housed within the Vermont Department of Health. |
| SMHE staffing (full-time equivalents) | 0.5 |
| Advisory committee or panel | None |

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.
3 Vermont Department of Health's Health Equity website. Last accessed 7/31/17.
4 Vermont Department of Health's Strategic Plan 2014-2018 (2014). Available on the VDOH website. Last accessed 7/31/17.
5 Social Determinants of Health: Health Equity Scorecard (2017). Available on the VDOH website. Last accessed 7/31/17.

## Program Goals and Activities

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Office of Health Equity | OHE |
| Vermont Department of Health | VDOH |

Health equity is one of six goals identified in the *Vermont Department of Health Strategic Plan 2014-2018*. Last updated in 2016, the plan outlines three strategic directions to help realize this objective: (1) reduce health disparities in communities that experience a disproportionate burden of disease, (2) recruit and retain qualified candidates from diverse backgrounds, and (3) translate documents for people with limited English proficiency. The plan, as well as accompanying performance scorecards that the VDOH uses to monitor progress on its goals, are publicly available on the VDOH's website. Each scorecard tracks statewide population data and program performance measures; one specifically focuses on social determinants of health and health equity.

The VDOH Commissioner's Office sets health equity goals and uses data to drive decision-making. To that end and in collaboration with the Division of Health Surveillance, a major OHE strategy is to assist in data collection and analysis. For example, the OHE works with each division of the VDOH to examine data for potential disparities and inequities; it also has enhanced Healthy Vermonters 2020,[6] the state's Health Assessment Plan, by adding five new data elements focusing on social determinants of health. The OHE will continue to advocate for inclusion of health disparities measurement in future updates of the State Health Assessment Plan and State Health Improvement Plan.

In line with the VDOH strategic plan, the OHE works to foster cultural competence throughout the department. The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, which emphasize structural and systemic changes to improve cultural competence, provide the framework for these efforts. New hires are required to complete online cultural competency training within 60 days of hire. The department is expanding and revising this training, and is developing additional ongoing educational opportunities for staff engagement related to cultural competence. In addition, both the OHE and the VDOH support best practices to recruit and retain candidates from diverse backgrounds. Both the department and the OHE are also committed to language access efforts, per the VDOH Strategic Plan's directive to translate 90 percent of the VDOH's translation committee-identified health documents and related materials by 2017.

### Partnerships

| | |
|---|---|
| Primary collaborators | • Burlington Local Health Office<br>• Pride Center of Vermont<br>• Refugee Health Committee<br>• Vermont Agency of Human Services |
| Contracts or memoranda of understanding with any partners | No partnerships include formal contracts or memoranda of understanding |

Partnerships are at the core of the OHE's work. As such, it collaborates with both governmental and nongovernmental entities committed to achieving health equity. One natural partner is the Refugee Health Committee, which is chaired by the OHE director in her capacity as the VDOH's Refugee Health Program's refugee health coordinator. The committee meets bimonthly to address community needs, issues, and concerns related to refugee health. Its membership includes health workers, community organizations, representatives from the U.S. Committee for Refugees and Immigrants (Vermont's resettlement agency), and others. The OHE director's dual role with the Refugee Health Program has also strengthened the VDOH's relationship with the refugee resettlement agency working in Vermont. In addition, the OHE has been meeting with the Sudanese Foundation of Vermont to better understand needs and interests affecting the health of Vermont's Sudanese community. The OHE also partners with the Burlington Local Health Office, one of 12 district offices reporting to the VDOH, to support interpreter training and emergency preparedness. Burlington's office oversees the state's most diverse region, which has the largest health disparities and is a key site for refugee resettlement.

The OHE also leads several Equal Employment Opportunity efforts for the VDOH's parent entity, the Vermont Agency of Human Services, and facilitates health equity-related partnerships for other VDOH divisions. For example, the OHE has helped establish a relationship between the Vermont Tobacco Control Program and the Pride Center of Vermont to develop

6 State Health Assessment Plan: Healthy Vermonters 2020 (2012). Available on the VDOH website. Last accessed 7/31/17.

smoking cessation efforts targeting the lesbian, gay, bisexual, and transgender (LGBT) populations. In fact, the OHE also established its own partnership with the Pride Center of Vermont to address issues related to HIV, hepatitis C, and alcohol and drug abuse in LGBT communities. Although some VDOH programs and offices have formal relationships with the Pride Center of Vermont to address these issues, the OHE itself does not have a contract or memorandum of understanding with any partners.

Finally, the OHE partners with a variety of organizations focusing on rural and agricultural communities. For example, the OHE participates in the Farm Health Task Force,[7] which aims to build and sustain a healthy farm workforce through targeted information-sharing and outreach efforts related to farm safety, migrant and immigrant farm worker health, and practitioner education.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | N/A |
| Annual budget (FY 2015) of SMHE from state/territorial government | N/A |
| Largest funding source | N/A |
| Anticipated changes to budget | None |

The OHE receives no direct funding from the state or other sources for its operations. The OHE director/refugee health coordinator position is funded through grants to address specific health issues that disproportionately affect minorities (e.g., substance use disorders and emergency preparedness).

7 Information about the Vermont Farm Health Task Force is available on the Champlain Valley Area Health Education Center's website. Last accessed 7/31/17.

# Vermont

## Vermont State Data

| Total Population[a]: 624,594 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 2.0 | 98.1 | 94.2 | 0.9 | 0.5 | 1.2 | 3.2 | 100.0 | NA |
| Percent of population medically uninsured[a] | 0.3 | 3.6 | 3.4 | 19.6 | 0.0 | 2.1 | 3.6 | 3.5 | 10.2 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 4.5 | 4.7 | SP | SP | SP | NC | 4.6 | 5.9 |
| Age-adjusted mortality rate[b] | 319.2 | 715.2 | 717.1 | 636.9 | SP | 480.5 | NC | 712.8 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 18.9 | 15.5 | 15.6 | 15.9 | 22.6 | 5.5 | 17.0 | 15.5 | 13.6 |
| Percent with diabetes[c] | 3.6 | 8.4 | 8.3 | 6.2 | 25.0 | 6.4 | 9.2 | 8.4 | 10.8 |
| Percent with heart disease[c] | 1.1 | 3.7 | 3.6 | 0.0 | 19.1 | 3.0 | 4.7 | 3.7 | 4.3 |
| HIV rate[d] | 604.5 | NC | 101.9 | 1068.4 | 0.0 | 103.2** | 337.0 | 123.7 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 68.2 | 70.2 | 70.4 | 63.0 | 66.7 | 75.6 | 62.9 | 70.3 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 65.1 | 72.3 | 72.7 | 55.1 | 40.6 | 83.7 | 65.1 | 72.2 | 66.5 |
| Percent received flu vaccine[c] | 48.4 | 41.5 | 42.2 | 29.2 | 34.5 | 25.4 | 40.4 | 41.7 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

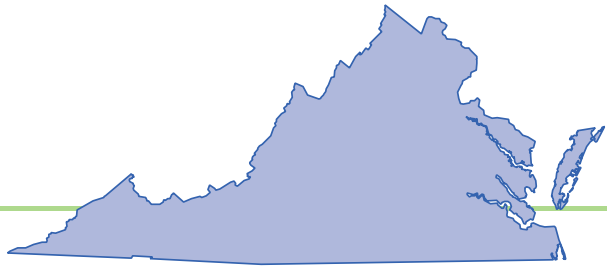
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 103.2 per 100,000 population (9 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 609.8 per 100,000 population (1 case).

# Virginia



## Introduction to Virginia's Health Equity Activities

Virginia had an estimated 2016 population of 8,412,000. Blacks/African Americans are the largest racial-ethnic minority population (19 percent), followed by Hispanics/Latinos (9 percent), Asians/Pacific Islanders (7 percent), and American Indians/Alaskan Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 6 percent of the population.[1] Approximately 1,528,000 Virginia residents live within a primary care health professional shortage area.[2]

The Virginia Department of Health's (VDH) Office of Health Equity (OHE) includes the Division of Multicultural Health and Community Engagement, the Division of Rural Health, the Division of Social Epidemiology, and the Primary Care Office. The OHE's initiatives and activities address minority health, health disparities, and health equity. Its mission is to identify health disparities and their root causes, and to promote equitable opportunities to be healthy.[3] The OHE director also serves as a senior adviser on minority health to the Virginia State Health Commissioner.

### Virginia Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Health Equity |
| Strategic plan in place to address minority health or health equity | At the time of data collection, both the Virginia Department of Health and the Office of Health Equity were developing strategic plans that address minority health, health disparities, and health equity as part of the larger goal of improving the health of all Virginians. |
| Date strategic plan was last updated | 2014 |
| Assessment plan in place to measure progress toward reducing health disparities | The Virginia Department of Health strategic plan evaluates inequality and disparities at a community level. |
| Key strategies used to achieve health equity | • Policies: Improve internal policies to bolster the Virginia Department of Health infrastructure to address health equity.<br>• Education: Educate staff of the Virginia Department of Health and other government agencies, and inform the public about health equity.<br>• Programming: Support faith-based community programs to promote health prevention, and school-based programs to increase high school graduation rates. |

## Organizational Structure

The OHE includes the Division of Multicultural Health and Community Engagement, the Division of Rural Health, the Division of Social Epidemiology, and the Primary Care Office. Its purview includes minority health, health disparities, and health equity in the context of other initiatives and activities. The OHE director serves as a senior adviser on minority health to the Virginia State Health Commissioner. In addition, the Commissioner's Advisory Committee on Health Disparities and Health Equity serves as a resource on minority health, health disparities, and health equity. Its tasks are to identify the limits of current services, programs, regulations, and laws; review disease prevention and health promotion strategies; support legislation and policies to improve health service delivery and accessibility; and make recommendations to the Virginia State Health Commissioner.[4]

1 American Community Survey Public Use Microdata, 2016.
2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.
3 Virginia Department of Health. Division of Multicultural Health and Community Engagement. Available on the VDH website.
4 Virginia Department of Health, Office of Health Equity. Commissioner's Advisory Council on Health Disparity and Health Equity. Available on the VDH website.

The OHE has 13 full-time staff members, 2 part-time staff members, and 8 contractors. Its staff members work on all activities in the OHE's four units. The OHE staff include an office director, a director of multicultural health and community engagement, a director of primary care and rural health, a social epidemiology and shortage designations manager, a senior policy adviser, a Partners in Prayer and Prevention coordinator, a social epidemiologist, a social epidemiologist/spatial analyst, two health workforce coordinators, a health equity specialist, a community health specialist, a rural health specialist, a health workforce specialist, a social epidemiologist assistant, a communications specialist, a human resource analyst, and a program support technician. The OHE's Division of Multicultural Health and Community Engagement also has one unpaid intern. The OHE does not expect staffing to change in the next 2 years.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The OHE is housed within the Virginia Department of Health. |
| SMHE staffing (full-time equivalents) | 13 |
| Advisory committee or panel | Commissioner's Advisory Council on Health Disparity and Health Equity |

## Program Goals and Activities

The OHE was developing a strategic plan at the time of data collection. The VDH strategic plan for 2014–2016 addressed health equity as part of its goal to improve the health of all Virginians. It included an assessment process, with associated metrics, and addressed health equity by evaluating inequalities and disparities at a community level across Virginia. The OHE strategic plan will align with the VDH strategic plan. The OHE's priorities are informed by a state health equity report, communicating with stakeholders, and analyzing health data. The Virginia Health Opportunity Index, a composite of 13 environmental, social, demographic, and educational indicators that relate to each community's well-being, was established by the OHE and helps identify areas needing intervention. It includes metrics calculated at census tract and county levels.[5]

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Virginia Department of Health | VDH |
| Office of Health Equity | OHE |
| Division of Multicultural Health and Community Engagement | DMHCE |

The OHE employs a range of strategies to achieve health equity. One is to bolster the VDH infrastructure through internal policymaking to advocate for health equity. By integrating health equity into strategic planning processes, such as the State Health Improvement Plan or the VDH strategic plan, the OHE believes that the VDH is better prepared to engage in health equity activities in Virginia.

Another strategy relates to enhancing cultural competency. Specifically, the OHE educates VDH staff and local health department staff on health equity issues using a cultural competency training series. During quarterly training sessions, VDH staff can attend in person or by videoconference. The OHE also educates the broader public through speaking engagements on health equity and social determinants of health.

Through its programming strategy, the OHE is collaborating in a faith-based community program called Partners in Prayer and Prevention, which derived from a previous initiative called Congregations for Million Hearts. Partners in Prayer and Prevention facilitates partnerships with faith and interfaith organizations, marginalized communities, and the VDH. The OHE initially focused on targeted distribution of VDH-approved information on prevention of the Zika virus.[6] However, the OHE later expanded this strategy to target chronic diseases.

5 Virginia Department of Health, Office of Health Equity. Virginia Health Opportunity Index. Available on the VDH website.

6 Virginia Department of Health. Partners in Prayer and Prevention (P3). Available on the VDH website.

# Virginia

## Partnerships

| | |
|---|---|
| Primary collaborators | • American Heart Association<br>• Danville Public Schools<br>• Pittsylvania/Danville Health District<br>• Virginia Oral Health Coalition<br>• Virginia Commonwealth University |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships |

The OHE collaborates with several partners to address minority health, health disparities, and health equity issues. As part of its education strategy, the OHE disseminates information (e.g., via newsletter) about educational opportunities and community events (e.g., town halls or trainings) sponsored both by governmental and nongovernmental organizations across Virginia. For instance, the Virginia Commonwealth University's Center on Health Disparities holds a monthly Health Disparities Roundtable lecture and discussion series, which the OHE recounts in its newsletter.

It also has informal partnerships across several activities with Virginia Commonwealth University's Center on Health Disparities, Center on Society and Health, and Department of Family Medicine and Population Health. The Center on Health Disparities develops the capacity of students, staff, faculty, and community partners to identify and develop interventions to reduce health disparities.[7] Staff from the OHE sits on the Center on Health Disparities' steering committee and assists with the center's community engagement programs. The University's Center on Society and Health studies the implications of social factors on health[8] and is working with the Department of Family Medicine and Population Health and the Robert Graham Center for Policy Studies in Family Medicine and Primary Care to merge census and electronic health records data, connecting economic and social challenges with patients' health.[9] The Center on Society and Health informally advises the OHE on data analysis, such as the Virginia Health Opportunity Index. The OHE also engages other academic institutions as stakeholders when identifying priorities.

Informal collaborations between the OHE and the American Heart Association grew out of the OHE's work with Congregations for Million Hearts, a faith-based initiative for raising awareness about reducing the risks of stroke and heart disease.[10] The OHE seeks to align that initiative (now known as Partners in Prayer and Prevention) with the American Heart Association's EmPOWERED to Serve program, which works with multicultural communities to increase healthy living behaviors.

The OHE informally collaborates with the Virginia Oral Health Coalition, and recognizes that oral health is unavailable and/or inaccessible to many vulnerable individuals and communities. To advance oral health equity, an OHE representative sits on the Virginia Oral Health Coalition's clinical advisory board, and attends and presents at various community, regional, and board meetings. The OHE director presented at the annual Virginia Oral health Summit in 2016.[11]

Some of the OHE's partnerships are more formal. For example, the OHE formally collaborates with the Pittsylvania/Danville Health District and Danville Public Schools. Danville has Virginia's lowest on-time graduation rate, and its graduation rate is much lower among boys and African Americans than girls and members of other racial and ethnic groups. The collaboration supports implementation of the Youth Health Equity Leadership Initiative, which provides targeted ninth-grade students with leadership and self-efficacy skills, with the goal of improving the on-time graduation rate among racial and ethnic minority youth.[12]

7 Virginia Commonwealth University Center on Society and Health, About the Center on Society and Health website.
8 Virginia Commonwealth University Center on Society and Health. About the Center on Society and Health website.
9 Virginia Commonwealth University Center on Society and Health. (2017). Community Vital Signs website.
10 Virginia Department of Health. Congregations for Million Hearts. Available on the VDH website.
11 Virginia Oral Health Coalition. 2016 Virginia Oral Health Summit. Available at the Virginia Oral Health's website.
12 U.S. Department of Health and Human Services Office of Minority Health. Grant Program; STATE PARTNERSHIP INITIATIVE TO ADDRESS HEALTH DISPARITIES (SPI).

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $2,900,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | Unavailable |
| Largest funding source | Unavailable |
| Anticipated changes to budget | None |

The total FY 2015 funding for the OHE was $2,900,000. The OHE funds activities related to its four units, including rural health, primary care, social epidemiology and data analysis, and multicultural health and community engagement. The OHE received a grant for $200,000 from the U.S. Office of Minority Health to implement the Youth Health Equity Leadership Initiative with the Pittsylvania/Danville Health District and Danville Public Schools.[13] The OHE does not expect funding to change in the next 2 years. The OHE does not provide funding to nongovernmental entities.

13 U.S. Department of Health and Human Services Office of Minority Health. Grant Program; STATE PARTNERSHIP INITIATIVE TO ADDRESS HEALTH DISPARITIES (SPI).

# Virginia

## Virginia State Data

| Total Population[a]: 8,411,808 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 9.0 | 91.0 | 68.0 | 19.0 | 0.3 | 6.5 | 6.3 | 100.0 | NA |
| Percent of population medically uninsured[a] | 25.6 | 7.3 | 7.8 | 10.0 | 6.8 | 8.1 | 19.6 | 9.0 | 10.2 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 4.0 | 6.2 | 4.8 | 10.1 | SP | 4.0 | NC | 5.9 | 5.9 |
| Age-adjusted mortality rate[b] | 342.2 | 728.4 | 708.5 | 850.8 | 292.6 | 360.6 | NC | 715.5 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 11.2 | 13.5 | 13.2 | 15.7 | 15.0 | 10.2 | 12.8 | 13.5 | 13.6 |
| Percent with diabetes[c] | 4.3 | 11.0 | 10.5 | 14.9 | 10.8 | 3.9 | 5.0 | 10.6 | 10.8 |
| Percent with heart disease[c] | 0.7 | 3.9 | 4.0 | 4.0 | 7.0 | 0.3 | 3.4 | 3.8 | 4.3 |
| HIV rate[d] | 338.0 | NC | 135.5 | 949.6 | 83.5 | 58.2** | 498.7 | 307.7 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 67.7 | 76.1 | 74.7 | 83.7 | 66.4 | 75.0 | 63.4 | 75.9 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 59.7 | 72.3 | 73.7 | 66.2 | 50.9 | 76.2 | 57.3 | 71.6 | 66.5 |
| Percent received flu vaccine[c] | 33.6 | 43.5 | 45.0 | 38.4 | 30.1 | 40.0 | 40.2 | 43.2 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

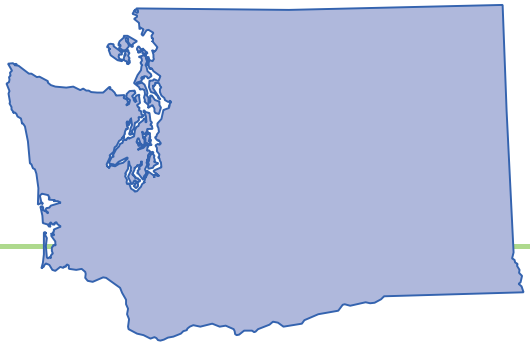
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 58.2 per 100,000 population (258 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 160.7 per 100,000 population (8 cases).

# Washington



## Introduction to Washington's Health Equity Activities

Washington had an estimated 2016 population of 7,288,000. Hispanics/Latinos are the largest racial-ethnic minority population (12 percent), followed by Asian Americans and NHOPI (9 percent), Blacks/African Americans (4 percent), and American Indians/Alaska Natives (1 percent). Persons self-identifying as multiracial or "other race" comprise 11 percent of the population.[1] Approximately 3,230,000 Washington residents live within a primary care health professional shortage area.[2]

In 2006, the Washington State Legislature created the Governor's Interagency Council on Health Disparities (GICHD) to eliminate racial, ethnic, and gender-based health disparities by race, ethnicity, and gender in the state. Of its 17 members, 14 represent state agencies or consumer groups and 3 are appointed by the governor.[3] The GICHD makes policy recommendations regarding cultural competency and other health equity issues and develops the State Policy Action Plan to Eliminate Health Disparities. Additionally, the Washington State Department of Health's (DOH) Health Equity Workgroup was established in 2014 to lead and support initiatives to achieve health equity.

### Washington Minority Health Overview

| | |
|---|---|
| Name of state/territorial minority health entity | Governor's Interagency Council on Health Disparities |
| Strategic plan in place to address minority health or health equity | *Governor's Interagency Council on Health Disparities: State Action Plan to Eliminate Health Disparities* |
| Date strategic plan was last updated | December 2016 |
| Assessment plan in place to measure progress toward reducing health disparities | There is no formal assessment plan, but the Governor's Interagency Council on Health Disparities plans to collect data on 16 key indicators. |
| Key strategies used to achieve health equity | **Governor's Interagency Council on Health Disparities:**<br>• Health impact reviews<br>• Implementing National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care<br>**DOH Health Equity Workgroup:**<br>• Building infrastructure and workforce to support health equity (e.g., improving data collection with the Health Disparity Tool, forging partnerships)<br>• Evaluating the impact of proposed legislation on health equity and tribal health<br>• Educating DOH staff, partners, and the public about health equity and diversity<br>• Requiring diversity and inclusion training for all DOH staff<br>• Promoting use of DOH's Health Disparities Index |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 Governor's Interagency Council on Health Disparities: About Us. Available on the state's "healthequity" website. Last accessed 8/5/17Health Equity. Available on the VDH website.

## Organizational Structure

The GICHD, established by state legislation, is independent and completely distinct from the DOH. Its co-chairs are gubernatorial appointees, and all 17 volunteer members who commit time to Council activities. Several staff members from the State Board of Health support the GICHD (e.g., the GICHD manager is employed by the State Board of Health and devotes 100 percent time to minority health and health equity activities). Several staff from the Washington State Board of Health also support the Council as part of their day-to-day responsibilities. In addition, the DOH has three staff members who spend 100 percent time on health equity activities.

Ad hoc advisory committees help the GICHD develop policy recommendations. For each GICHD-identified priority topic area, the legislature mandates the formation of an advisory committee—comprised of members from different races, ethnicities, genders, and organization affiliations—to aid the GICHD in developing policy recommendations. Once the GICHD issues policy recommendations for the topic area, the advisory committee disbands.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The GICHD is an independent body, distinct from the DOH. |
| SMHE staffing (full-time equivalents) | 3 (plus 17 volunteers) |
| Advisory committee or panel | By statute, ad-hoc advisory committees must be convened to guide the GICHD in providing policy recommendations to the governor and legislature. |

Within the DOH, the Health Equity Workgroup includes diverse staff from across the department. Official responsibilities of five workgroup members explicitly identify health equity, and each devotes a portion of their time to health equity activities. They include: a director of community relations and equity (40 percent), a chief of civil rights and risk management (60 percent), a tribal liaison (100 percent), a community relations and equity consultant (100 percent), and a health equity consultant (100 percent). Other DOH staff spend time supporting minority health through their work on broader health initiatives. Volunteers and student interns occasionally support the DOH and the Health Equity Workgroup on minority health efforts.

## Program Goals and Activities

The GICHD developed its first *State Action Plan to Eliminate Health Disparities* in 2010, which it updated in December 2016.[4] The Action Plan includes recommendations for the governor and legislature to eliminate health disparities. The GICHD's authorizing statute lists 16 diseases and conditions that the Council must address. To establish its priorities, the GICHD obtains input from various sources, including its authorizing legislation, topical briefings, and community input. Although the GICHD does not have a formal assessment plan to measure progress toward reducing health disparities, it plans to monitor data on the 16 diseases and conditions specified in the statute. Health equity is also a guiding principle of the DOH's *2017–2019 Strategic Plan*, which identifies health disparity reduction and ensuring health equity among two of its six core goals.[5]

Established by the Secretary of Health in 2014, the Health Equity Workgroup is comprised of staff representing DOH divisions and has an internal work plan that specifies strategies and activities to reduce health disparities. The work plan aligns with the GICHD's recommendations and federal priorities for reducing health disparities. Available health disparity data, along with community input, help drive priority setting within the DOH.

The GICHD promotes health equity through state action planning and other ongoing activities. In collaboration with the Washington State Board of Health, the GICHD supports health impact reviews for proposed legislation and budgetary changes. These health impact reviews assess how a bill would likely affect health and health disparities. The governor or any state legislator can request a health impact review for any legislative proposal or budgetary change.[6]

4 *Governor's Interagency Council on Health Disparities: State Action Plan to Eliminate Health Disparities*. Available on the Governor's Interagency Council on Health Disparities' website. Last accessed 8/5/2017.

5 *Department of Health Strategic Plan: September 2016-August 2019*. Available on the Washington State Department of Health website. Last accessed 8/5/2017.

6 Washington State Board of Health. Health Impact Reviews. Available on the DOH website. Last accessed 8/5/17.

# Washington

## Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Governor's Interagency Council on Health Disparities | GICHD |
| Department of Health | DOH |

Another priority for both the GICHD and the DOH is implementation of the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). In partnership with the DOH, the GICHD developed online training modules about the National CLAS Standards that are specific to Washington and appropriate for health care providers and state agency staff. The GICHD is encouraging state agencies to adopt and implement the National CLAS Standards. Within the DOH, the Center for Public Affairs is leading efforts to implement the Standards. Specifically, the Center for Public Affairs is consulting with staff across the DOH to develop program-specific plans for the National CLAS Standards implementation, identify existing cultural or linguistic barriers, and determine how program staff can overcome obstacles with available resources.

The GICHD also views promoting equity in state government as a strategy to achieve health equity. In its *State Action Plan to Eliminate Health Disparities*, the GICHD urged the governor to consider issuing policies to, for example, diversify the government workforce to better reflect state demographics, improve the "cultural humility" of state employees, and ensure that state-supported organizations promote health equity.[7]

In addition to the GICHD's efforts, the DOH's Health Equity Workgroup is responsible for identifying and supporting strategies that promote health equity. For example, to better evaluate the impact of proposed legislation on health equity and tribal health, the Health Equity Workgroup successfully promoted the inclusion of two new questions to the standard bill analysis template—one addressing health equity and one addressing tribal health. Health Equity Workgroup members then assessed how these new questions are used by conducting interviews with senior leaders and reviewing how legislative analysts answered these questions. In response to their findings, workgroup members developed targeted training and resource materials. The Health Equity Workgroup plans to continue investigating the health equity and tribal health components of the bill analysis template as part of continuing quality improvement efforts.

To promote health equity dialogue among DOH staff, the Health Equity Workgroup organizes a lecture series, *Health Equity & Diversity (HED) Talks*, in which guest speakers discuss health equity or diversity issues with DOH staff. The HED Talks occur three times per year, and each is followed by an opportunity for DOH staff to meet and discuss presentation content in small groups. Other activities supported by the Health Equity Workgroup include staff training and promoting the use of the Health Disparities Index—a part of the DOH Washington Tracking Network's Information by Location tool.

## Partnerships

| | |
|---|---|
| Primary collaborators | • Community-based organizations<br>• Racial and ethnic state commissions<br>• State agencies<br>• State Board of Health<br>• Tribal entities |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships |

Organizations represented within the GICHD membership are key GICHD partners in the effort to achieve health equity. These include state agencies (i.e., Department of Agriculture, Department of Commerce, Department of Early Learning, Department of Ecology, Department of Health, Department of Social and Health Services, Health Care Authority, Office of Superintendent of Public Instruction, State Board of Health, and Workforce Training and Education Coordinating Board). Commissions represented within the GICHD membership (i.e., American Indian Health Commission, Commission on African American Affairs, Commission on Asian Pacific American Affairs, and Commission on Hispanic Affairs) also collaborate heavily with the GICHD.

7 *Governor's Interagency Council on Health Disparities: State Action Plan to Eliminate Health Disparities*. Available on the Governor's Interagency Council on Health Disparities' website. Last accessed 8/5/2017.

Several community-based organizations partner with the DOH to advise and implement programs. For example, to address disparities around chronic disease prevention, the DOH collaborates with the Center for MultiCultural Health, El Centro de la Raza, and Asian Pacific Islander Coalition Advocating Together (APICAT). The Gay City Health Project, which serves the lesbian, gay, bisexual, transsexual, and questioning community, works with the DOH on activities related to HIV/AIDS disparities, as well as tobacco and marijuana use prevention.

To facilitate coordination and partnership with Washington's tribal entities, a DOH staff member serves as a full-time tribal liaison, meeting monthly both with the Secretary of Health and tribal health leaders to discuss health issues and priorities. The American Indian Health Commission and the Seattle Indian Health Board are also key partners in addressing equity issues affecting the state's Indian populations. Contractual work with the American Indian Health Commission focuses primarily on chronic disease prevention and maternal and child health.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | $137,000 to support the Governor's Interagency Council on Health Disparities |
| Annual budget (FY 2015) of SMHE from state/territorial government | $137,000 |
| Largest funding source | State |
| Anticipated changes to budget | Unknown |

In FY 2015, the State Board of Health received $137,000 from the state to support the GICHD. Funding for GICHD support has been steady at this level since FY 2012. Additionally, since FY 2012, the state has allocated $94,000 to the State Board of Health for health impact reviews. In FY 2015, no federal funding supported GICHD operations or activities.

The DOH did not have dedicated funding for health equity work in FY 2015. Minority health and health equity work is part of broader DOH activities funded by state and/or federal sources and, therefore, cannot be disaggregated. While some DOH staff are fully dedicated to minority health and health equity initiatives, many other staff support minority health through population health initiatives that integrate health equity approaches, creating a challenge in determining total budgetary resources for staff salaries. The DOH provides funding to several partner organizations to advance health equity, including the Center for MultiCultural Health, the American Indian Health Commission for Washington State, the Seattle Indian Health Board, Gay City Health Project, El Centro de la Raza, and the Asian Pacific Islander Coalition Against Tobacco.

# Washington

## Washington State Data

| Total Population[a]: 7,288,000 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 12.4 | 87.6 | 75.7 | 3.7 | 1.3 | 8.8 | 10.5 | 100.0 | NA |
| Percent of population medically uninsured[a] | 16.5 | 4.5 | 4.9 | 6.7 | 14.8 | 5.1 | 13.5 | 6.0 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 4.6 | 4.7 | 4.6 | 8.5 | SP | 4.2 | NC | 4.9 | 5.9 |
| Age-adjusted mortality rate[b] | 464.0 | 679.6 | 686.4 | 729.9 | 844.4 | 413.4 | NC | 672.0 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 12.9 | 15.1 | 15.4 | 18.8 | 27.4 | 6.9 | 14.8 | 14.9 | 13.6 |
| Percent with diabetes[c] | 7.3 | 9.6 | 9.6 | 13.3 | 14.7 | 6.4 | 7.9 | 9.4 | 10.8 |
| Percent with heart disease[c] | 1.5 | 3.9 | 4.2 | 2.3 | 4.2 | 1.4 | 2.2 | 3.7 | 4.3 |
| HIV rate[d] | 273.8 | NC | 173.2 | 878.3 | 167.9 | 82.5** | 389.8 | 208.3 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 58.5 | 65.7 | 65.2 | 71.5 | 61.3 | 66.1 | 61.3 | 65.2 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 57.1 | 70.1 | 70.0 | 64.0 | 56.5 | 72.7 | 61.9 | 69.2 | 66.5 |
| Percent received flu vaccine[c] | 33.0 | 40.9 | 41.3 | 29.9 | 36.7 | 40.7 | 33.1 | 40.3 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

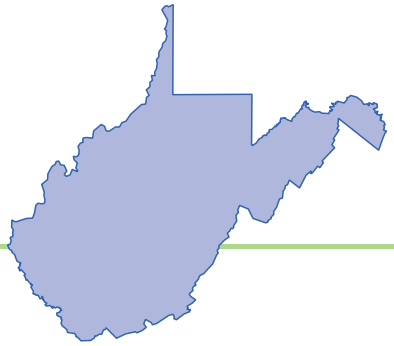
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 82.5 per 100,000 population (412 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 143.4 per 100,000 population (54 cases).

# West Virginia



## Introduction to West Virginia's Health Equity Activities

West Virginia had an estimated 2016 population of 1,831,000. Blacks/African Americans are the largest racial-ethnic minority population (4 percent), followed by Hispanic/Latinos (1 percent), Asian Americans and NHOPI (1 percent), and American Indians/Alaska Natives (less than 1 percent). Persons self-identifying as multiracial or "other race" comprise 2 percent of the population.[1] Approximately 628,000 West Virginia residents live within a primary care health professional shortage area.[2]

The Department of Health and Human Resources (DHHR), Bureau of Public Health's (BPH) Office of Minority Health (OMH) was established in 2014. The OMH addresses barriers to health care, risk reduction, healthier lifestyle choices, health care service usage, health promotion, and disease prevention.[3] Its mission is to "eliminate health disparities for vulnerable populations as defined by race/ethnicity, socio-economic status, geography, age, disability status, and among other populations identified to be at-risk for health disparities."[4]

### West Virginia Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Minority Health |
| Strategic plan in place to address minority health or health equity | The Office of Minority Health plans to develop a strategic plan regarding minority health, health disparities, and health equity. |
| Date strategic plan was last updated | N/A. |
| Assessment plan in place to measure progress toward reducing health disparities | The Office of Minority Health's strategic plan will include an assessment plan. |
| Key strategies used to achieve health equity | • Reduce and eliminate tobacco use in targeted minority populations.<br>• Reduce and eliminate obesity and diabetes as well as promote healthy lifestyles.<br>• Address behavioral health and substance abuse. |

## Organizational Structure

The OMH addresses the health of minority populations by bringing a focus on health equity issues to the DHHR's health promotion efforts. The Minority Health Advisory Team, established by the OMH, is comprised of professionals from public and private sector organizations and advises the OMH around the development of programs and services necessary to eliminate health disparities. It is also assisting the OMH in developing its first *Minority Health Strategic State Plan*. The OMH has one full-time staff position (currently vacant) who serves as the BPH's minority health coordinator and dedicates 100 percent time to health equity initiatives. The OMH,

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 West Virginia Department of Health and Human Resources, Bureau of Public Health, Office of Minority Health. (July 2013). Office of Minority Health CHARTER.

4 West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Minority Health. Activities Report 2016 (July 1, 2015 – June 30, 2016).

BPH, and DHHR also have volunteers who work on minority health, health disparities, and health equity. Staff allocations are not expected to change.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The OMH is housed within the West Virginia Department of Health and Human Resource, Bureau of Public Health's Health Improvement Section |
| SMHE staffing (full-time equivalents) | 1 (vacant) |
| Advisory committee or panel | Minority Health Advisory Team |

## Program Goals and Activities

Overarching goals of the OMH are to promote and strengthen health data collection; increase awareness of major health issues affecting vulnerable populations; establish and strengthen coalitions and partnerships to solve health problems; develop practices, programs, and policies that achieve health equity; and provide training, seminars, and technical assistance.[5]

The OMH plans to develop a strategic state plan, which will include a process to evaluate progress towards specific goals. In the meantime, the DHHR strategic plan identifies priorities that contribute to the OMH's goals and activities. The OMH also prioritizes activities based upon analyses of health data. One such analysis has identified vulnerable populations not previously recognized. The OMH is also addressing data improvement efforts. For instance, the DHHR conducts a behavioral health risk factors survey,[6] but until recently, it had not consistently collected gender identity and/or sexual orientation information. Emerging evidence from recent data analyses indicate that the lesbian, gay, bisexual, or transsexual (LGBT) populations are among the most vulnerable in the state. Such evidence allows the OMH to set priorities to address health disparities affecting LGBT communities.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Department of Health and Human Resources | DHHR |
| Bureau for Public Health | BPH |
| Office of Minority Health | OMH |

The OMH makes use of several strategies to improve minority health and health equity in the state. Such strategies target particularly vulnerable minority populations. For example, to reduce tobacco use, the OMH collaborates with the Division of Tobacco Prevention, along with other state and federal programs, to provide services and educate targeted minority populations across the state.

In 2014, West Virginia had the second-highest prevalence of obesity (i.e., 36 percent of its population) and the fourth-highest prevalence of diabetes (i.e., 14 percent of its population) nationally.[7] As part of its strategy to address obesity and diabetes, the OMH collaborates with the Division of Health Promotion and Chronic Disease and the Bureau for Medical Services, among other organizations, to assist individuals with diabetes, prediabetes, and obesity by connecting Medicaid recipients with diabetes self-management programs and diabetes prevention programs, among other aspects of the program. The OMH also has increased awareness of oral health, physical activity, and nutrition through education, and by providing screening information.

5 West Virginia Department of Health and Human Resources, Bureau of Public Health, Office of Minority Health. (July 2013). Office of Minority Health Charter.

6 Crouch, Gupta, Williams, & Christy (2014). West Virginia Behavioral Risk Factor Surveillance System Report 2014. Available on the DHHR website. Last accessed 5/12/2017.

7 West Virginia Department of Health and Human Resources, Bureau of Public Health (2014). West Virginia Behavioral Risk Factor Surveillance System Report 2014. Available on the DHHR website. Last accessed 5/12/2017.

# West Virginia

## Partnerships

| | |
|---|---|
| Primary collaborators | State agencies:<br>• Bureau for Medical Services<br>• Division of Health Promotion and Chronic Disease<br>• Division of Primary Care<br>• Division of Rural Health and Recruitment<br>• Division of Tobacco Prevention<br>• Oral Health Program<br><br>Other organizations:<br>• Adolescent Health Coalition<br>• American Cancer Society<br>• Association of State and Territorial Health Officials<br>• Bonnie's Bus<br>• Coalition for a Tobacco-Free West Virginia<br>• Healthy Steps<br>• Marshall Medical Outreach<br>• Mountains of Hope Cancer Coalition<br>• Susan G. Komen West Virginia<br>• Try This West Virginia<br>• West Virginia Association of Free Clinics<br>• West Virginia Breast and Cervical Cancer Screening Programs<br>• West Virginia Cancer Registry<br>• West Virginia Health Right<br>• West Virginia Immunization Network<br>• West Virginia Oral Health Coalition |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships |

The OMH works with both governmental and nongovernment organizations to eliminate health disparities. For example, the OMH collaborates with the Coalition for a Tobacco-Free West Virginia to reduce tobacco use among minority populations and to identify particularly at-risk minority populations. Together, the OMH and the Coalition for a Tobacco-Free West Virginia conduct outreach with minority communities and provide educational resources related to tobacco use. The OMH also collaborates with the Division of Tobacco Prevention which, in turn, collaborates with other federal, state, and nongovernmental partners. The Division of Tobacco Prevention offers cessation services and distributes education materials designed for targeted at-risk groups, including pregnant women, African Americans, those over age 55, LGBT populations, and low-income communities.

To improve health behaviors and related outcomes, the OMH collaborates with Try This West Virginia, an effort to increase awareness of nutrition, physical activity, and oral health in minority communities. Efforts are coordinated with a faith-based initiative, Healthy Bodies Healthy Spirits, which seeks to increase physical activity and healthy nutrition habits.

The OMH also collaborates with the Division of Health Promotion and Chronic Disease and other organizations as part of its strategy to reduce and eliminate diabetes and obesity among minority populations. To address socioeconomic health disparities, the Division of Health Promotion and Chronic Disease collaborates with the Bureau for Medical Services to connect Medicaid beneficiaries to nongovernmental and federal diabetes prevention and self-management programs.

Recognizing the significant barriers to achieving oral health among all West Virginians, the OMH collaborates with the West Virginia Oral Health Coalition and the BPH's Oral Health Program. The West Virginia Oral Health Coalition seeks to provide oral health access to uninsured adults, implement a multidisciplinary oral health plan, cover adult restorative procedures by expanding Medicaid benefits, and change the oral health culture in West Virginia.[8]

Reducing disparities in cancer care is another focus of the OMH. The OMH collaborates extensively with the Mountains of Hope Cancer Coalition (which represents health care professionals, community advocates, volunteers, cancer survivors, the American Cancer Society, and the BPH) to promote cancer prevention among minority communities, educate individuals with cancer, and assist cancer patients with their care. For example, the two organizations work to increase cancer awareness through community outreach with Bonnie's Bus and Susan G. Komen West Virginia. They also partner with the Association of State and Territorial Health Officials to implement the Healthy Steps initiative in Harrison and Kanawha Counties. In addition, the OMH collaborates with the West Virginia Cancer Registry and the West Virginia Breast and Cervical Cancer Screening Program to increase breast cancer awareness among minority women.

8 West Virginia Oral Health Coalition: About Us. Available on the West Virginia Oral Health Coalition's website. Last accessed 5/12/2017.

The OMH has developed other partnerships to address specific concerns. For example, it partners with the Division of Primary Care to ensure that racial and ethnic minorities have access to health care services through community health centers, school-based health centers, and satellite centers. Through a collaboration with the Division of Rural Health and Recruitment, the OMH also works to advance health equity among rural populations in West Virginia. Further, the OMH collaborates with the Adolescent Health Initiative, a longstanding coalition supported through the DHHR, to educate and improve minority adolescent health through community organizations.[9]

Finally, the OMH is also engaged in decision-making and policy development to expand an influenza initiative; for this effort, it partners with the West Virginia Health Right, the West Virginia Immunization Network, and the West Virginia Association of Free Clinics, among others.

## Funding

| | |
|---|---|
| Annual budget (FY 2017) of state/territorial minority health entity (SMHE) across all income sources | $90,000 |
| Annual budget (FY 2017) of SMHE from state/territorial government | $90,000 |
| Largest funding source | State government |
| Anticipated changes to budget | Unknown |

Total FY 2015 funding for the OMH was $90,000, all of which is allocated by the state. The OMH provided less than $10,000 in minigrants to advance health equity. It is unclear if OMH funding will remain stable or decline in the future.

9 Adolescent Health Initiative. Adolescent Health Initiative Home Page. Available on the DHHR website. Last accessed 5/12/2017.

# West Virginia

## West Virginia State Data

| Total Population[a]: 1,831,102 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 1.4 | 98.6 | 93.1 | 3.9 | 0.1 | 0.8 | 2.1 | 100.0 | NA |
| Percent of population medically uninsured[a] | 16.0 | 5.3 | 4.9 | 15.2 | 10.9 | 7.4 | 9.4 | 5.4 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 7.1 | 6.7 | SP | SP | SP | NC | 7.1 | 5.9 |
| Age-adjusted mortality rate[b] | 266.0 | 948.3 | 945.5 | 1049.4 | SP | 202.9 | NC | 943.3 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 4.7 | 16.3 | 16.0 | 18.8 | 21.9 | SP | 23.8 | 16.2 | 13.6 |
| Percent with diabetes[c] | 11.9 | 15.0 | 14.9 | 15.2 | 15.9 | SP | 12.5 | 15.0 | 10.8 |
| Percent with heart disease[c] | 2.1 | 8.0 | 8.1 | 4.5 | 10.0 | SP | 12.2 | 8.0 | 4.3 |
| HIV rate[d] | 391.4 | NC | 81.9 | 729.2 | 29.5 | 54.8** | 541.4 | 113.3 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 73.5 | 79.1 | 78.9 | 80.8 | 89.8 | SP | 77.3 | 79.0 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 55.1 | 57.8 | 58.1 | 57.3 | 49.5 | SP | 45.4 | 57.8 | 66.5 |
| Percent received flu vaccine[c] | 26.2 | 44.8 | 44.8 | 43.3 | 42.6 | SP | 29.6 | 44.6 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

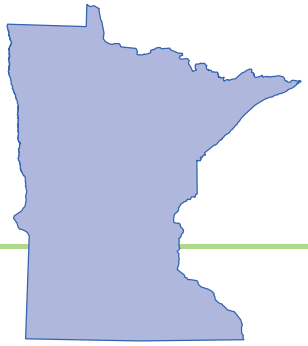
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 54.8 per 100,000 population (7 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 0.0 per 100,000 population (0 cases).

# Wisconsin



## Introduction to Wisconsin's Health Equity Activities

Wisconsin had an estimated 2016 population of 5,779,000. Hispanics/Latinos are the largest racial-ethnic minority population (7 percent), followed by Blacks/African Americans (6 percent), Asians/Pacific Islanders (3 percent), and American Indians/Alaska Natives (1 percent). Persons self-identifying as multiracial or "other race" comprise 5 percent of the population.[1] Approximately 1,401,000 Wisconsin residents live within a primary care health professional shortage area.[2]

Housed within the Wisconsin Department of Health Services' (DHS) Division of Public Health (DPH), the Minority Health Program (MHP) was created to provide "statewide leadership for policy measures that aim to improve the health of vulnerable populations in Wisconsin."[3] It is charged with coordinating DPH efforts to reduce health disparities, administering community grants, and implementing a public health information campaign. It also publishes a Minority Health Report and provides administrative support to the Minority Health Advisory Group.

### Wisconsin Minority Health Overview

| | |
|---|---|
| Name of state/territorial minority health entity | Wisconsin Department of Health Services, Division of Public Health, Office of Policy and Practice Alignment, Minority Health Program |
| Strategic plan in place to address minority health or health equity | The Wisconsin Department of Health Services developed a strategic state health plan, *Healthiest Wisconsin 2020: Everyone Living Better, Longer*,[4] which identifies eliminating health disparities and achieving health equity as crosscutting priorities. |
| Date strategic plan was last updated | *Healthiest Wisconsin 2020: Everyone Living Better, Longer* was last updated in 2010. |
| Assessment plan in place to measure progress toward reducing health disparities | The Wisconsin Department of Health Services is developing performance measures intended to track progress toward reducing health disparities. |
| Key strategies used to achieve health equity | • Increasing the Wisconsin Division of Public Health's capacity to eliminate health disparities<br>• Advising on data collection and standardization efforts<br>• Implementing the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care and developing a plan for individuals with limited English proficiency<br>• Providing grant funding to support the work of community-based organizations serving socially disadvantaged minority populations |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

3 The Wisconsin Department of Health Services, Division of Public Health, Minority Health Program webpage. Available on the Wisconsin DHS website. Last accessed 8/4/2017.

4 Healthiest Wisconsin 2020: Everyone Living Better, Longer. A State Health Plan to Improve Health Across the Life Span, and Eliminate Health Disparities and Achieve Health Equity. Available on the Wisconsin DHS website. Last accessed 8/4/2017.

## Organizational Structure

The Department of Health Services is comprised of nine distinct divisions, including the DPH. Within the DPH are eight bureaus and offices, including the Office of Policy and Practice Alignment, which oversees the MHP. Its current advisory committee is the Minority Health Advisory Group, which consists of 15 community representatives with diverse backgrounds from across the state.

In 2015, the DPH and the MHP developed a plan to restructure the MHP's staffing and funding structure. This required replacing the MHP's three previous staff positions (an office manager, a policy analyst, and a program director) with three new positions intended to align with the DPH's strategies for addressing health disparities. The new staff positions include an outreach coordinator, a training officer, and an epidemiologist. Many DPH staff outside of the MHP also dedicate time to minority health activities.

| | |
|---|---|
| Location of state/territorial minority health entity (SMHE) within state/territorial government | The Minority Health Program is housed within the Department of Health Services, Division of Public Health, Office of Policy and Practice Alignment. |
| SMHE staffing (full-time equivalents) | 3 |
| Advisory committee or panel | Minority Health Advisory Group |

## Program Goals and Activities

Eliminating health disparities and achieving health equity are key priorities identified in the DHS strategic state health plan, *Healthiest Wisconsin 2020: Everyone Living Better, Longer*. The DHS is required to produce a state health plan every 10 years. Beginning in 2015, the DHS began developing a new health improvement plan through the Wisconsin Health Improvement Planning Process. The new health improvement plan will build on Healthiest Wisconsin 2020 and will be updated every 5 years. In addition to the DHS's strategic state health plan, the MHP has a stand-alone operational plan that focuses on how it can support the DPH in its efforts to advance health equity.

The DHS aligns health equity priorities with other statewide priorities. Various DHS divisions and programs are involved in priority setting for the MHP, as are non-governmental groups such as local health departments and the Great Lakes Inter-Tribal Council. Within the DPH, some bureaus create "equity action teams" that establish health equity priorities specific to their bureaus. The MHP has played a key role in setting health equity priorities and encouraging the DHS to link priorities to actionable disparities. The MHP also has been working with the DHS to develop performance measures intended to monitor progress on its efforts. The DHS and its partners will report on progress to the Wisconsin Public Health Council, which was created to monitor and advise on implementation of the state health plan, and will also track progress on a publicly available website.

To align with the DHS's health equity priorities, the DPH adopted a crosscutting approach in which each DPH bureau shares a responsibility for eliminating health disparities and advancing health equity. The MHP serves primarily as a resource within the DPH, supporting the bureaus and programs on activities related to minority health and health disparities. Accordingly, many of the MHP strategies aim to increase the DPH's capacity to advance health equity. One strategy involves coordinating with other DPH programs and partners. Many of the bureaus and programs within the DPH have dedicated staff focusing on minority health and health equity activities. For example, the Wisconsin AIDS/HIV Program works on specific initiatives targeting minority populations, such as increased HIV testing and outreach in communities of color, and cultural competency training for health care providers. The Tobacco Prevention and Control Program is another example; it funds smoking prevention initiatives that target specific racial and ethnic minority populations where disparities exist. The MHP's role is to help build partnerships, such as establishing a community of practice—an internal group intended to act as an equity advisory team within the DPH. The overall goal of these partnerships is to make it easier for the DPH's bureaus and programs to reduce health disparities.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Wisconsin Department of Health Services | DHS |
| Wisconsin Division of Public Health | DPH |
| Minority Health Program | MHP |

# Wisconsin

In addition to building partnerships, the MHP also advises the DPH and its partners on data collection and data analysis efforts. Toward the goal of improving the quality of data used to identify disparities, the MHP provides training to improve data collection efforts, such as the collection of vital records data, and is helping to standardize the way disparities data are used throughout the DPH.

Another strategy of the MHP focuses on the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). The MHP promotes National CLAS Standards implementation within the DPH and among its partners. To support this strategy, the MHP provides training, develops resources, and maintains a webpage to disseminate information on the National CLAS Standards. The MHP also developed a National CLAS Standards Pledge. DHS programs and partners that sign this pledge agree to adopt, promote, and implement the National CLAS Standards; promote health equity; and help to eliminate health disparities. The MHP also helped develop the DPH's Language Access Plan to ensure that its programs, services, and activities are accessible to individuals with limited English proficiency.

Community-based organizations working to address the social determinants of health can apply for grant awards issued by the MHP. Four such programs are targeted to:

1. Support community health workers across different ethnic groups in their efforts to identify the most prominent social determinants of health
2. Promote skills learning for unemployed and underemployed individuals
3. Improve health literacy within the Hmong population living in north-central Wisconsin
4. Promote peer breastfeeding support for African American women.

## Partnerships

| | |
|---|---|
| Primary collaborators | • CORE/El Centro<br>• Great Lakes Inter-Tribal Council<br>• Hmong American Center<br>• Local health departments<br>• Racine Kenosha Community Action Agency<br>• Urban League of Greater Madison<br>• Wisconsin Division of Public Health bureaus and programs |
| Contracts or memoranda of understanding with any partners | Yes, contracts or memoranda of understanding are implemented for some partnerships |

A key priority of the MHP is to advance health equity by expanding DPH partnerships. The MHP works collaboratively with grantees to support that goal. The grantee organizations—CORE/El Centro, Hmong American Center, Racine Kenosha Community Action Agency, and Urban League of Greater Madison—provide quarterly progress reports to the MHP. The MHP also conducts site visits with grantees and, moving forward, will be working to align grant programs with statewide priorities.

In addition to working with community-based organizations, the MHP collaborates with local health departments and a variety of DPH sections, including the Bureau of Communicable Diseases and the Bureau of Community Health Promotion. The MHP also works with the Great Lakes Inter-Tribal Council in efforts to eliminate health disparities and advance health equity.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | ~$250,000 |
| Annual budget (FY 2015) of SMHE from state/territorial government | ~100,0000 |
| Largest funding source | Federal government |
| Anticipated changes to budget | Unknown |

In FY 2015, the total funding for the MHP was approximately $250,000. The MHP received approximately $100,000 from the State of Wisconsin and approximately $150,000 from a 2-year State Partnership Initiative to Address Health Disparities (SPI) grant from the U.S. Office of Minority Health. The last year of the SPI grant was FY 2015. The MHP provided funding to four grantees in 2015. Each grantee received $25,000 over 2 years.

As part of the MHP's restructuring, the State of Wisconsin increased the amount of funding allocated to the MHP in 2016. The increase in funding came from Wisconsin general revenue and was intended to fund MHP's three full-time staff positions in an effort to bring more stability to the program.

# Wisconsin

## Wisconsin State Data

| Total Population[a]: 5,778,709 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 6.7 | 93.3 | 85.5 | 6.2 | 0.9 | 2.8 | 4.6 | 100.0 | NA |
| Percent of population medically uninsured[a] | 16.3 | 4.7 | 4.6 | 9.4 | 16.4 | 7.0 | 13.6 | 5.4 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | 5.5 | 5.8 | 4.4 | 14.9 | SP | 6.4 | NC | 5.8 | 5.9 |
| Age-adjusted mortality rate[b] | 450.7 | 724.1 | 702.4 | 1009.6 | 848.1 | 468.3 | NC | 720.9 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 9.6 | 11.9 | 11.8 | 15.2 | 18.4 | 4.6 | 13.2 | 11.9 | 13.6 |
| Percent with diabetes[c] | 5.6 | 10.0 | 9.7 | 13.4 | 20.3 | 0.0 | 7.3 | 9.7 | 10.8 |
| Percent with heart disease[c] | 1.3 | 4.8 | 4.9 | 2.4 | 8.1 | 0.8 | 1.2 | 4.6 | 4.3 |
| HIV rate[d] | 304.6 | NC | 64.9 | 772.0 | 76.6 | 63.9** | 305.4 | 122.0 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 64.8 | 71.8 | 71.1 | 85.9 | 69.4 | 58.4 | 67.8 | 71.5 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 55.0 | 73.8 | 75.0 | 60.0 | 48.8 | 62.4 | 61.2 | 73.1 | 66.5 |
| Percent received flu vaccine[c] | 34.0 | 36.2 | 36.5 | 29.7 | 20.9 | 47.1 | 32.8 | 36.2 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

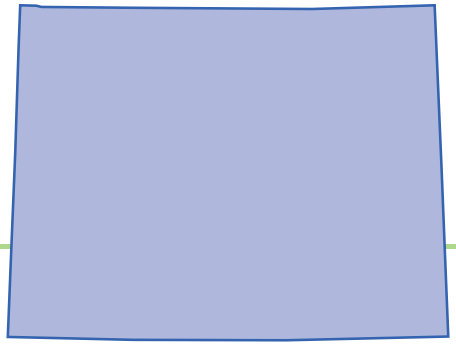
c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 63.9 per 100,000 population (78 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 67.1 per 100,000 population (1 case).

# Wyoming



## Introduction to Wyoming's Health Equity Activities

Wyoming had an estimated 2016 population of 529,000. Hispanics/Latinos are the largest racial-ethnic minority population (10 percent), followed by American Indians/Alaska Natives (3 percent), Asians/Pacific Islanders (1 percent), and Blacks/African Americans (1 percent). Persons self-identifying as multiracial or "other race" comprise 4 percent of the population.[1] Approximately 159,000 Wyoming residents live within a primary care health professional shortage area.[2]

Established in 2006, the Wyoming Office of Health Equity (OHE) was originally called the Wyoming Office of Multicultural Health. Its goals are to minimize health disparities among underserved populations—through networking, partnerships, education, collaboration, and advocacy—and to promote culturally competent programs aimed at improving health equity. Internal and external advisory committees advise the OHE on minority health, health disparities, and health equity. The internal advisory committee, the Health Equity Workgroup (HEW), was created in 2014 as part of its strategic plan and meets regularly. The Multicultural Health Advisory Committee has been the external advisory body since 1980; due to funding constraints, it no longer meets regularly.

### Wyoming Minority Health Overview

| | |
|---|---|
| Name of state/ territorial minority health entity | Office of Health Equity |
| Strategic plan in place to address minority health or health equity | Integrated into the Public Health Division's strategic map. |
| Date strategic plan was last updated | 2013 |
| Assessment plan in place to measure progress toward reducing health disparities | No |
| Key strategies used to achieve health equity | • Building capacity for language interpretation<br>• Building internal capacity to address health equity<br>• Increasing awareness and education<br>• Building infrastructure with Native American tribes |

## Organizational Structure

Within the Department of Health's (DOH) Division of Public Health, the OHE is housed in the Rural and Frontier Health Unit. One mid-level staff person has a sole commitment to the OHE and chairs the HEW, which consists of DOH employees who volunteer to serve on the workgroup. The OHE does not include volunteers or interns, but external volunteers work on health equity community projects. There are no plans to increase the number of staff working on minority health and health equity initiatives.

| | |
|---|---|
| Location of state/ territorial minority health entity (SMHE) within state/territorial government | The OHE sits within the Rural and Frontier Health Unit of the DOH's Division of Public Health. |
| SMHE staffing (full-time equivalents) | 1 staff committed to OHE activities |
| Advisory committee or panel | Health Equity Workgroup and Multicultural Health Advisory Committee |

1 American Community Survey Public Use Microdata, 2016.

2 Health Resources and Services Administration. 2018. Designated Health Professional Shortage Areas Statistics: First Quarter of Fiscal Year 2018 Designated HPSA Quarterly Summary.

## Program Goals and Activities

The OHE does not have a stand-alone strategic plan, but the Public Health Division of the Wyoming DOH has a strategic map that includes a cultural competency component. The Public Health Division's strategic map, drafted in 2012 and updated in 2013, led to the 2014 creation of the HEW, which is responsible for determining OHE's actions and tasks. A plan to assess progress on meeting OHE's goals is not yet available. Staff at multiple levels within the DOH use a health equity assessment tool to set minority health priorities.

To increase awareness of and address health disparities and health equity issues, the OHE has several priority areas. For example, to build capacity for language interpretation, the OHE offers two trainings in different parts of the state that focus on medical communication and apply to interpreters speaking any language. The OHE plans to launch a website that will connect individuals with local interpreters. To support building internal capacity to address health equity, the OHE is performing an assessment within the DOH and developing web-based classes for employees to address identified knowledge gaps. Dispersed employees can participate in these webinars. A DOH administrator requires a baseline training for all employees and drives all programs to address social determinants of health in the populations they serve. Monthly speakers are invited to present to DOH staff on health equity topics, such as collecting data on social determinants of health. To support tribal infrastructure around health disparity reduction, the OHE helps a tribal coalition build capacity and address goals. This tribal coalition, which meets monthly, has worked to develop education about the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards). Collectively these initiatives benefit programs within the DOH, particularly those that serve economically disadvantaged populations, the elderly, individuals with mental health conditions, and American Indians.

### Acronym List

| Full Name of Agency Acronym | Acronym |
|---|---|
| Wyoming Department of Health | DOH |
| Office of Health Equity | OHE |
| Health Equity Workgroup | HEW |

### Partnerships

| | |
|---|---|
| Primary collaborators | • Wind River Indian Reservation<br>• Transportation services<br>• County governments<br>• Police departments |
| Contracts or memoranda of understanding with any partners | No partnerships include formal contracts or memoranda of understanding |

The OHE partners with tribal agencies and other local governmental agencies to achieve health equity objectives. For example, it works with agencies within the Wind River Indian Reservation to inform them of grant opportunities and trainings. The OHE also provides technical assistance for the Reservation's health equity conference and is helping them to analyze data on health disparities. Reservation agencies also participate in a roundtable on health disparities. To address access barriers to health care, the OHE works with local transportation providers that serve tribal residents and other at-risk populations. The OHE assists county transportations departments with grant applications by providing supporting data.

In addition, the OHE works with county governments on nurse training and other initiatives. The OHE requires county-level public health response coordinators to track at-risk individuals as part of emergency response. Finally, the OHE works with local police departments to conduct cultural competency trainings and performs other support functions on an as-needed basis.

## Funding

| | |
|---|---|
| Annual budget (FY 2015) of state/territorial minority health entity (SMHE) across all income sources | The Rural and Frontier Health Unit received state general revenue funding and applies some of this funding to the OHE, but none is designated for the OHE specifically. |
| Annual budget (FY 2015) of SMHE from state/territorial government | Not applicable |
| Largest funding source | State government |
| Anticipated changes to budget | None |

The Rural and Frontier Health Unit applies available funding to the OHE, but OHE activities do not receive a specific amount. In FY 2015, Wyoming general revenue was the sole source of funding for the Rural and Frontier Health Unit. The DOH, which expects reduced funding overall in the future, does not plan to set aside funding specifically for the OHE; the amount of funding that the Rural and Frontier Health Unit may apply to the OHE could decline.

# Wyoming

## Wyoming State Data

| Total Population[a]: 528,626 | Ethnicity | | Race | | | | | Totals | |
|---|---|---|---|---|---|---|---|---|---|
| | Hispanic or Latino | Not Hispanic or Latino | White | Black or African American | American Indian/ Alaska Native | Asian American and NHOPI* | Multi-racial or Other | State Total | National Total |
| **Population Characteristics** | | | | | | | | | |
| Percent of state population[a] | 9.7 | 90.3 | 92.0 | 0.9 | 2.5 | 1.1 | 3.5 | 100.0 | NA |
| Percent of population medically uninsured[a] | 17.9 | 10.5 | 10.4 | 7.6 | 40.3 | 7.0 | 12.3 | 11.2 | 8.9 |
| **Health Disparities** | | | | | | | | | |
| Vital Statistics | | | | | | | | | |
| Infant mortality rate[b] | SP | 4.8 | 4.7 | SP | SP | SP | NC | 4.9 | 5.9 |
| Age-adjusted mortality rate[b] | 521.0 | 732.4 | 723.0 | 352.8 | 957.3 | SP | NC | 728.8 | 728.8 |
| Prevalence of Selected Chronic Diseases | | | | | | | | | |
| Percent with asthma[c] | 13.1 | 14.1 | 13.4 | SP | 28.1 | SP | 21.8 | 14.0 | 13.6 |
| Percent with diabetes[c] | 9.7 | 8.1 | 7.9 | SP | 10.6 | SP | 12.4 | 8.3 | 10.8 |
| Percent with heart disease[c] | 3.5 | 4.0 | 4.1 | SP | 2.2 | SP | 2.3 | 4.0 | 4.3 |
| HIV rate[d] | 134.2 | NC | 45.8 | 417.3 | 107.2 | 44.4** | 96.5 | 59.3 | 362.3 |
| Preventive Services | | | | | | | | | |
| Percent received routine check-up (past 12 months)[c] | 55.5 | 65.7 | 65.9 | SP | 63.9 | SP | 57.3 | 65.1 | 72.2 |
| Percent received oral health visit (past 12 months)[c] | 59.3 | 67.5 | 68.4 | SP | 51.4 | SP | 53.5 | 67.1 | 66.5 |
| Percent received flu vaccine[c] | 31.8 | 35.2 | 35.7 | SP | 31.6 | SP | 29.6 | 35.2 | 38.4 |

**Key** NA = Not applicable, NC = Not collected by the data source, SP = Suppressed due to small numbers.

a Source: American Community Survey Public Use Microdata, 2016.

b Source: CDC Wonder Online Database for vital statistics. Infant mortality rate is the number of deaths per 1,000 births in 2015. Age-adjusted mortality rate is the number of deaths per 100,000 population in 2016.

c Source: Behavioral Risk Factor Surveillance System, 2016.

d Source: CDC National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas, 2015. Note that Hispanic individuals do not appear in any race categories in this dataset.

*Native Hawaiian and other Pacific Islander

**The CDC NCHHSTP Atlas's racial classifications separate Asian and Pacific Islander into distinct racial categories. HIV data in table reflects infection rate among Asians of 44.4 per 100,000 population (2 cases); HIV infection rate among Native Hawaiians and Other Pacific Islanders is 0.0 per 100,000 population (0 cases).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