HELP US FORGE A PATH TO HEALTH EQUITY

KATHY CURRAN and DARRYL ROBINSON

What is health equity, and how do we make it a reality? Healthy People 2020, a program of a nationwide health-promotion and disease-prevention goals, defines health equity as the "attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally, with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities." If we want to live in a society where there is health equity, we must be committed to identifying and eliminating health disparities, and we must recognize and reflect the diversity of those we serve.

A committee of the CHA board of trustees has been charged with advising CHA's board and staff on how the association and its members can be effective agents for change in the areas of leadership diversity, workforce diversity and health disparities, with a particular focus on traditionally underrepresented groups. As part of its work the Special Committee on Diversity and Health Disparities is called on to identify issues of particular concern to CHA's members and to recommend strategies for implementing the Catholic health ministry's commitment to health equity.

The committee recently completed a discernment process to develop a roadmap for its activities over the next several years. During that process, committee members considered CHA's strengths, the issues that are important to its members and the social justice commitment that frames the work of the Catholic health ministry.

The first thing the committee did was to identify an overall strategic purpose for CHA's health equity work. The committee believes that CHA's activities should seek to educate, advocate and accelerate for change, both within the CHA membership and externally. Developing and disseminating education resources for members and the public is a key CHA strength, and the association also has deep experience and expertise in advocacy work with members, outside groups and policymakers. Through activities of education and advocacy, we will seek to accelerate the pace of change. Both externally and internally, CHA will strive to be a leader in the movement to achieve health equity.

The committee decided to focus on four areas: the community benefit process as a key tool in addressing health disparities; disparities in access to behavioral and mental health; diversity and disparity issues in long-term care and end-of-life care; and racism and its effect on health.

USING THE COMMUNITY BENEFIT PROCESS

CHA and the Catholic health ministry are longtime leaders in the field of community benefit programs. Assessing community health needs and developing plans to address selected needs are essential elements for effective community benefit programs. Public health research shows

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that addressing the social determinants of health can have a major impact on improving population health and decreasing health disparities. Community health needs assessments and implementation strategies can be powerful tools for addressing health disparities and moving toward health equity.

In 2017 CHA asked members to complete a survey about their community health needs assessments and the prioritized needs they planned to address in their implementation strategies. About one-third of participants planned to address social determinants of health, and 16 percent named health disparities or health equity. Approximately 50 percent said that in addressing other prioritized needs, they also expected to achieve benefits related to health disparities or health equity. The committee is considering how to help the ministry use the CHNA process to increase health equity. Among the possibilities are:

- Identifying and sharing best practices among ministry community benefits programs that address health disparities or health equity
- Increasing the number of CHNAs and implementation strategies that specifically identify health disparities or health equity as a prioritized need
- Identifying one or two key social determinants of health that address health disparities and encouraging members to examine those needs in their communities

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ISSUES IN LONG-TERM AND ELDER CARE

The focus on health disparities and diversity mostly has been on acute care and primary care services. However, disparities in access and quality of care have been documented in the context of long-term care and elder care services. For example, the care and outcomes white and minority nursing home residents experience differ substantially, mostly due to the fact that Black and Hispanic individuals are more likely to reside in facilities that provide a lower quality of care.[1] Racial and ethnic minorities have less access to pain management services and palliative care.[2] Cultural differences and lack of trust can create racial, ethnic and religious barriers to palliative care and end-of-life decision-making. These differences between caretakers and elderly patients/residents also can create barriers in care as well as uncomfortable personal interactions.

As demographics change in the United States, it will become even more important to be aware of and address health disparities and issues related to cultural diversity with respect to care of our elders. AARP projects[3] that the number of people over 65 will almost double over the next few decades, going from 48 million in 2015 to 88 million in 2050. The increase will be driven largely by the numbers of racial and ethnic minorities turning 65. Members of minority groups constituted 22 percent of the over-65 population in 2015, but will represent 39 percent of that demographic in 2050.

CHA can play a role in educating its members and the public about such challenges by surveying existing research on health disparities in access and outcomes in long-term care and developing education and action resources. Working with the Supportive Care Coalition, a group of Catholic health systems collaborating to advance excellence in palliative care, CHA can help address disparities in access to and use of palliative care and end-of-life decision-making tools. As the aging population becomes more diverse, we must increase cultural competence and leadership diversity in our long-term care ministries in order to meet the needs of those we serve.

DISPARITIES IN BEHAVIORAL HEALTH ACCESS

CHA's members play a pivotal role in the delivery of mental and behavioral health services, and they know firsthand how harmful the gaps in the mental health system are to those they serve. Across the ministry, members are highlighting the need for more resources to address the nation's mental and behavioral health needs. This concern is heightened by the alarming increase in the incidence of opioid addiction and the devastating effect of violence on communities' mental health.

Although it appears that, overall, racial and ethnic minorities have a similar incidence of mental disorders as non-Hispanic whites do, significant disparities exist. For example, rates of depression are lower among blacks and Hispanics, but persistent depression is more likely for minorities. American Indian and Alaska Natives have higher rates of post-traumatic stress disorder and alcohol abuse. And although access to mental health services is insufficient to meet the need across society, minority groups are less likely to receive care — and if they get care, it is less likely to be quality care.[4]

We need to raise awareness of this problem. By collaborating with organizations that address mental and behavioral health, we can help to build cultural and linguistic competency among mental health providers and work to increase the number of practitioners from diverse communities. CHA already is involved in advocacy to expand funding for and access to mental and behavioral health services — we must continue those efforts and look for opportunities to support programs that address cultural differences. Dealing with the consequences of social factors such as poverty, violence and racism affects mental well-being. CHA can identify and highlight the work of its members to address these conditions in their communities.

HOW RACISM AFFECTS HEALTH

Racism within any context is an affront to the ministry's core values, which acknowledge the inherent dignity of each person, call for the furthering of the common good and seek justice.

We must recognize the effect racism has on the health of individuals and communities. Overt racism is, or should be, easy to identify and condemn. But racism is a pernicious evil. Bias based on race can be unintentional or unconscious. When public policy decisions affect people or groups disproportionately — whether in housing, employment, transportation or education — it serves to perpetuate inequities in our society and contribute to the existence of health disparities. Experts believe that the harmful physiological effects of stress caused by anticipating and managing racial injustice in our culture contribute to health disparities as well.[5]

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We cannot solve the problem of racism in our country, but we must be strong and vocal advocates against racism in all its forms. For instance, we can raise awareness of how racism affects health and health care. We can help the ministry increase diversity in the leadership, governance and workforce of our organizations through collaboration with partners such as the Institute for Diversity and Health Equity, which works closely with health services organizations to advance health equity for all and to expand leadership opportunities for ethnic minorities in health management. We can urge our political leaders to consider and address how our society is affected by racial injustice, which contributes to poor health outcomes for diverse populations. We can become aware of our own unconscious biases and make a renewed commitment to providing culturally competent health care to all of our patients. The Diversity and Health Disparities Committee will focus on these areas over the next few years.

CHA has many strengths and tools to draw on: advocacy, convening, education, resource development and sharing ministry best practices. There are many partners to collaborate with: Catholic colleagues at Catholic Charities

and the Supportive Care Coalition, as well as secular organizations seeking to address these same issues. But the most important partners are CHA's members. As the committee begins to chart a course of action, it needs members to share ideas, provide examples of successful programs and interventions and to help get the word out. Together, we can forge a society in which health equity is a reality.

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NOTES

1. Jennifer Gaudet Hefele et al., "Examining Racial and Ethnic Differences in Nursing Home Quality," *The Joint Commission Journal on Quality and Patient Safety*, 43:11 (2017): 554–64.
2. Kimberly S. Johnson, MD, MHS, "Racial and Ethnic Disparities in Palliative Care," *Palliative Medicine* 2013 Nov. 16 (11): 1329-34.; "Disparities in Access to Palliative Care," *Health Affairs Blog*, July 30, 2014. DOI: 10.1377/hblog20140730.040327
3. AARP, Across the States: Profiles of Long Term Services and Supports 2018.
4. Mental Health Disparities: Diverse Populations, *American Psychiatric Association*, 2017; Agency for Healthcare Quality and Research. 2010 National Healthcare Quality and Disparities Reports.
5. See, e.g., Elizabeth A. Pascoe and Laura Smart Richman. "Perceived Discrimination and Health: A Meta-Analytic Review," *Psychological Bulletin* 135.4 (2009): 531–54. PMC. Web. 2 Oct. 2018.

U.S. Postal Service

STATEMENT OF OWNERSHIP, MANAGEMENT, AND CIRCULATION

(Required by 39 U.S.C. 3685)

1. Title of publication: *Health Progress*
2. Publication number: *0882-1577*
3. Date of filing: *November 1, 2018*
4. Issue Frequency: *Bi-monthly*
5. No. of issues published annually: *6*
6. Annual subscription price: *$55 domestic, $75 foreign*
7. Location of known office of publication: *4455 Woodson Rd., St. Louis, MO 63134-3797*
8. Location of headquarters of general business offices of the publisher: *4455 Woodson Rd., St. Louis, MO 63134-3797*
9. Names and complete addresses of publisher, editor, and managing editor: *Catholic Health Association, Publisher; Mary Ann Steiner, Editor; Lilah Lohr, Managing Editor; 4455 Woodson Rd., St. Louis, MO 63134-3797*
10. Owner: *The Catholic Health Association of the United States, 4455 Woodson Rd., St. Louis, MO 63134-3797*
11. Known Bondholders, Mortgagees, and Other Security Holders: *None*
12. *The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes has not changed during the preceding 12 months.*
13. Publication name: *Health Progress*
14. Issue date for circulation data below: *September-October 2018*

	Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
15. Extent and nature of circulation:		
a. Total no. copies *(net press run)*	15,325	16,150
b. Paid and/or requested circulation		
(1) Paid/requested outside-county mail subscriptions stated on Form 3541	13,030	13,723
(2) Paid in-county subscriptions	0	0
(3) Sales through dealers and carriers, street vendors, counter sales, and other USPS paid distribution	0	0
(4) Other classes mailed through the USPS	0	0
c. Total paid and/or requested circulation *[sum of 15b (1), (2), (3), and (4)]*	13,030	13,723
d. Free distribution by mail *(Samples, complimentary, and other free)*		
(1) Outside-county as stated on Form 3541	1,748	1,914
(2) In-county as stated on Form 3541	0	0
(3) Other classes mailed through the USPS	0	0
(4) Free distribution outside the mail *(Carriers or other means)*	0	0
e. Total free distribution *(sum of 15d (1), (2), (3), (4))*	1,748	1,914
f. Total distribution *(Sum of 15c and 15e)*	14,778	15,637
g. Copies not distributed	433	400
h. Total *(sum of 15f and g)*	15,211	16,037
i. Percent paid and/or requested circulation *(15c divided by 15f times 100)*	88.21%	87.81%
16. This statement of ownership will be printed in the *November-December 2018* issue of this publication.		

I certify that the statements made by me above are correct and complete.

Mary Ann Steiner, Editor

JOURNAL OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES www.chausa.org

HEALTH PROGRESS®

Reprinted from *Health Progress*, November - December 2018