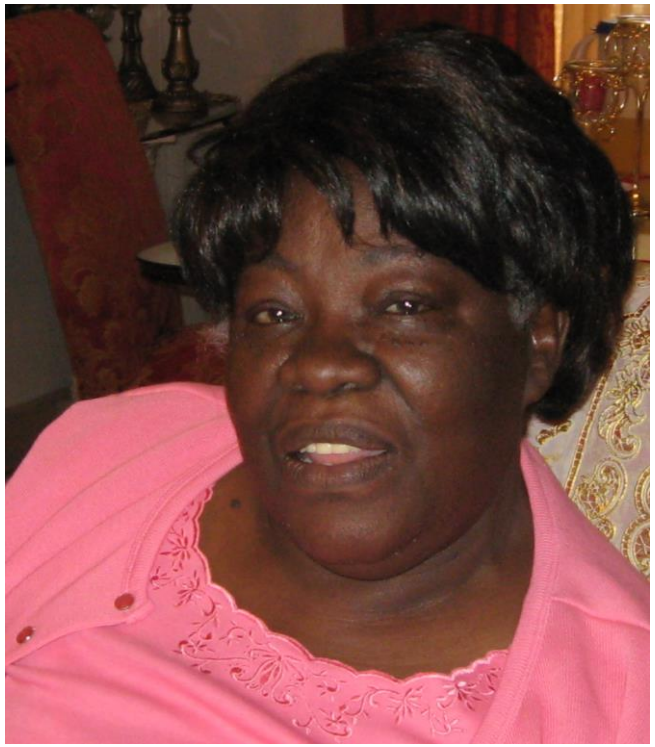
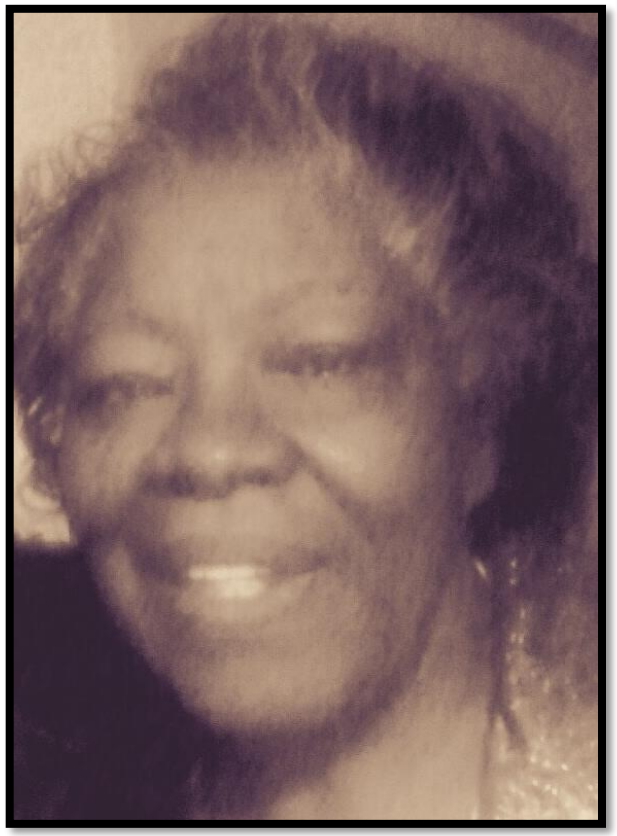
Addressing Health Equity for North Carolinians

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ITEMS FOR DISCUSSION

1. My Why? What's Yours?
2. The Case for Leading with Equity
3. Impact of COVID-19
4. Moving Forward – Using What we Know
5. Key Takeaways – What Can You Do?





NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Leading with Equity

Targeting efforts to those greatest in need

World Health Organization

"…the highest attainable standard of health … a fundamental right of every human being."

a. 1946
b. 1960
c. 1985

1

“A rights-based approach to health requires that health policy and programs must prioritize the needs of those furthest behind first towards greater equity..”

WHO IS FURTHEST BEHIND? WHY?

- **Historically Marginalized Populations**:
  - Individuals who have historically and systematically been denied access to services, resources and power relationships across economic, political, and cultural dimensions as a result of systemic, durable, and persistent racism, discrimination and other forms of oppression
  - Often identified based on their **race, ethnicity, social economic status, geography, religion, language, sexual orientation or gender identity and disability status**

- **Why?**:
  - Long standing and well documented structural marginalization has resulted in poor health outcomes, economic disadvantage, and increased vulnerability to harm and adverse social, political and economic outcomes

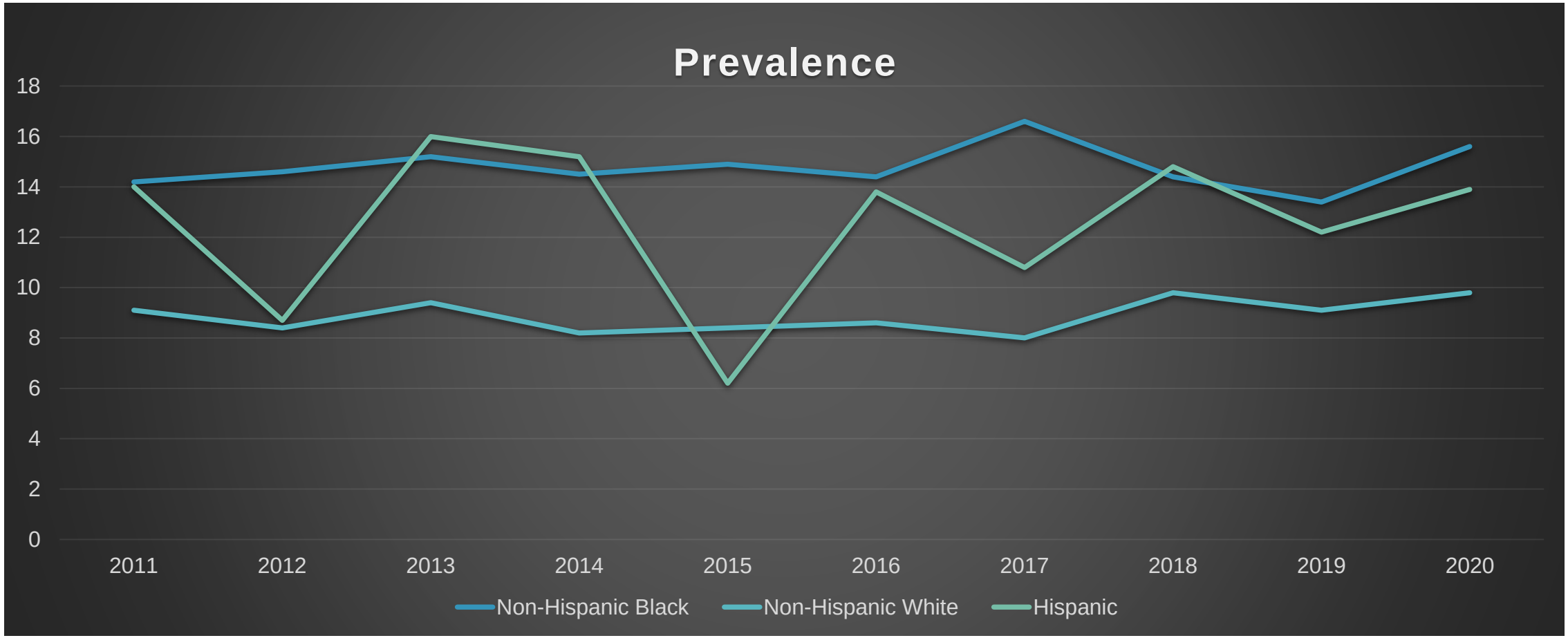
Population Health

United States	North Carolina
Life Expectancy: 78.79 years **Men**: 76.30 **Women:** 81.30	**Life Expectancy:** 77.6 years Men: 75.11 Women: 80.37
Infant Mortality Rate 5.6 infant deaths per 1,000 live births	Infant Mortality Rate 6.9 infant deaths per 1,000 live births
Maternal Mortality Rate (infant deaths per 1,000 live births): 17.4 deaths per 100,000 live births	Maternal Mortality Rate (infant deaths per 1,000 live births): 10.9 deaths per 100,000 live births
Obesity (Percent of the population) 67.1	Obesity (Percent of the population): 69.3%
Diabetes (percent of the population): 11.3% (diagnosed) 23% (undiagnosed)	**Diabetes** (percent of the population): 12.7% (diagnosed)
Leading cause of death: • Heart disease • Cancer • COVID	**Leading cause of death:** • Heart Disease • COVID • Stroke

American Indians 3x likely to be diagnosed; 2.3x more likely to die

African Americans 60% more likely to be diagnosed; 2x likely to die

Burden of Diabetes in NC



Data Source: BRFSS

COVID-19 IMPACT ON HISTORICALLY MARGINALIZED POPULATIONS

COVID-19 had disparate impact on historically marginalized populations, esp. people of color (Black and Brown people who often have chronic health conditions)

- ***Disparities in COVID cases***
- ***Hospitalizations***
- ***Deaths***

COVID-19 didn't create disparities but illuminated inequality.

HMPs at higher risk for contracting COVID-19, more severe illness, more challenging recovery from COVID-19

- **Pre-existing health disparities**
- **Historic, persistent, systemic/structural health disparities**

People of color overly-represented in front-line, low-wage positions in health care and service sectors

- **Direct contact with the public increases risk of exposure**
- **Secondary employment also increases risk of exposure**
- **Many of these jobs lack paid sick leave**

Social determinants/drivers play a role,

i.e., access to health insurance is a key barrier

Moving Forward

Leveraging COVID response as a roadmap for future responses

HEALTHY OPPORTUNITIES PILOTS

Taking Steps to Ensure All North Carolinians have the Opportunity for Health

- Address the "Other 80%"
- Improve whole-person health, safety and well-being of all North Carolinians while being good stewards of resources
- Intentionally, strategically, and pragmatically use dollars to "Buy Health"

- Worsened during the pandemic
- Drivers of health inequities
- Risk factors for chronic diseases
- Addressing can improve health and lower costs

Poverty:
- 16% of families with children live in poverty; 21% among North Carolina families with at least one child under age five.

Food:
- NC has the 8th highest rate of food insecurity in the US, with more than one in five children living in food insecure households.
- 7% are living in a food desert

Housing:
- Over 1.2 million North Carolinians cannot find affordable housing, and one in 28 of the state's children under age six is homeless.
- 30% of NC families reported having trouble paying usual household expenses.

Transportation:
- On average 7% of the state population do not have access to a vehicle and report that lack of transportation causes them to delay their medical care

Interpersonal Violence:
- 47% of NC women have experienced intimate partner violence.
- 23% of our children have experienced two or more adverse childhood events

NEXT PHASE: FOCUS ON RECOVERY WHILE STAYING PREPARED FOR FUTURE VARIANTS

Core Principles

- **Empowering individuals**
- **Prioritizing Equity**
- **Maintaining Health System Capacity**
- **Collaborating with Local Partners**

Operational Preparedness

Health System Capacity
- Working with GA on changes needed for regulation flexibilities after SOE sunset

Vaccines Everywhere
- "Vial in Every Fridge" Provider Campaign

Funding Testing Programs
- Building supply to meet future surge needs

Accessible Treatment
- Promoting access and awareness of how to access COVID treatment

Managing Outbreaks
- Working with partners and directly supporting outbreak response in high priority settings

Refocusing Contact Tracing
- Shifting focus to high priority settings

Recovering Stronger

Behavioral Health and Resiliency
- Offering services further upstream and expanding access to mental health care

Child and Family Wellbeing
- Investing in family and childhood development to build a stronger society

Strong and Inclusive Workforce
- Strengthening the workforce that supports early learning, health and wellness

Key Takeaways – What can you do?

WHAT CAN WE ALL DO?

Engage Communities for Partnerships & Solutioning Seek to engage disproportionally impacted communities in solution generation

Improve Language Access

- Materials must be available in Spanish and other languages

Address Social Drivers of Health

- Acknowledge and prioritize social drivers of health
- Intentionally address non-medical drivers of health

Use a Data-Driven Approach

- Prioritizing equity data requires that we focus on quantifying the disparity, while recognizing and acknowledging longstanding inequities
- Develop and follow a data strategy that will identify the underlying social inequities and the resources needed to afford all patients, consumers, guests, and constituents a fair and just opportunity to achieve their healthiest outcome.

Engage Providers of Color

- Leverage expertise of providers of color who have traditionally served Historically Marginalized Communities

Measure

- Change in outcomes among selected disadvantaged groups
- Gaps between disadvantaged and advantaged groups

HEALTH EQUITY FRAMEWORK: COVID-19 RESPONSE & MOVING FORWARD

Earn and sustain trust:

- **Honest communication** with accurate information
- **Partnerships** that build relationships
- **Co-create solutions** with communities
- **Data-driven** outreach

Embed equity in policy and operations:

- **Deploy levers** to minimize access barriers
- **Clear provider/vendor expectations on equity** for prevention and response activities
- **Resource community partners** for operations
- **Prioritize state resources for HMP communities (vendors, staffing, etc.)**

Share accountability:

- **Complete and consistent equity data** collected and reported publicly
- **Data-driven decision making** to better identify and serve our communities
- **Telling the Story** to amplify the efforts, stories and successes of equity promotion in NC

APPENDIX

PREPARING FOR THE NEXT POSSIBLE PANDEMIC: MOVING FORWARD TOGETHER

Declining trends and changes in available tools have allowed us to shift our efforts from response to management

Key Tools to Our Response:

Vaccines and boosters are widely available

Treatment is readily available for those at high risk of severe disease

PPE and tests are robustly available

On March 17th NC DHHS released:

Moving Forward Together: The Next Phase of North Carolina's COVID-19 Pandemic Response

>>> ***Moving Forward Together:*** The Next Phase of North Carolina's COVID-19 Pandemic Response

MARCH 2022

In March 2020, the first case of COVID-19 was identified in North Carolina. From the beginning, North Carolina built its response to the global pandemic using the latest available scientific knowledge, real-time data, robust partnerships, and community input, while putting heath equity at the center of all efforts. We created new programs to deliver significant resources – stockpiles of personal protective equipment, hundreds of "fast and fair" testing and vaccine sites, community health workers to connect individuals to services, and the technology and communication tools necessary to monitor and inform the public. And most importantly, North Carolinians came together to practice the 3 Ws – Wear, Wait, and Wash, and get vaccinated to protect themselves, their loved ones, and their communities.

Early in the pandemic when less was known about the virus, people did not have immunity, and treatment was not available, blunter tools were needed to save lives and preserve hospital capacity. As tools became available and the impacts of the virus shifted, our response molded to meet the moment. From the beginning, Governor Cooper has used data and the best scientific information available to drive our response which has allowed the state to avoid many of the worst effects of COVID-19.

North Carolina had the **lowest per capita deaths in the southeast** and **among the lowest in the nation.**

Statewide hospital capacity has **never exceeded 91%.**

Statewide ICU capacity has **never exceeded 89%.**

With the change in our trends and the tools now available, we can adapt our response for the current stage of the pandemic – moving from crisis response to disease management. Equity will remain at the center of our work, ensuring the right tools reach those most at risk for severe disease from COVID-19. And we will remain vigilant and respond to changes in the virus, ensuring the public is well informed. North Carolina has worked hard to get to this moment and NCDHHS will continue to work to support a strong recovery that supports health and wellbeing for all North Carolinians.

>>> *The Changing Context*

The COVID-19 landscape looks different today than it did two years ago and will continue to evolve. We have learned more about the virus and now have several effective tools that reduce risk for people.

- Vaccines and boosters are widely available and help protect against severe illness, hospitalization, and death.
- Treatment is available for those at higher risk of severe disease.
- We have a robust supply of testing and personal protective equipment.
- Immunity in North Carolina's population has increased dramatically, both from vaccination and from past infection. While people who have been infected with COVID-19 do have some protection against the virus, studies show that infection-acquired immunity waned after 1 year in unvaccinated participants but protection remained consistently higher than 90% in those who were subsequently vaccinated, even in persons infected more than 18 months previously.

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LESSONS LEARNED FOR MOVING FORWARD

Below, are lessons learned from operation of family vaccination sites during the COVID-19 response:

OPERATIONAL FEEDBACK

- **Critical for partners to be actively engaged/bought in rather than just use as a site**
  - The host sites should be engaged differently than just lending space, they should be a part of the planning and hosting process.
  - A major plus if the host site is a trusted messenger/partner of the community.
- **Extended hours of operation (i.e., timings offered outside of regular working hours) is essential**
  - Late evening/weekend availability creates opportunity for those who work/are unavailable during regular business hours.
- **Vaccines were not the main draw; incentives are important**
  - Incentives were a huge success: some people truly would not have gotten vaccinated if not coming for an incentive.

COMMUNITY OUTREACH FEEDBACK

- **Ensure that groups/organizations involved are fully trusted by the community**
  - Groups/organizations like religious organizations, cultural centers, food banks and other service centers often have deep connections and trust within the community to effectively get the word out re: vaccination centers and testing sites.
- **Stand-up, fixed sites for people to go to may not the best way to reach these populations: may need a more direct path to communities**
  - People may not have effective means of transportation to sites.
- **Social media ads were very effective in reaching to the community**
  - These ads need to be up and running well in advance–realizing that people will need to accurately plan childcare, transportation, etc.
- **Consider translating outreach materials in other languages besides English and Spanish**
- **Review most common languages spoken in the area to ensure we have accurately translated materials, CHWs proficient in those languages (dialects, etc.)**