

SB21-181- EQUITY STRATEGIC PLAN ADDRESS HEALTH DISPARITIES Concerning state agencies addressing health disparities in Colorado.

Details

Bill Sponsors:	Senate – Fields (D) and Coram (R) House – Herod (D) and Caraveo (D)
Committee:	Senate Health & Human Services Senate Appropriations
Bill History:	3/10/2021- Introduced in Senate Senate Health & Human Services Committee Refer Amended to Appropriations
Next Action:	Hearing in Senate Appropriations
Fiscal Note:	<u>March 18, 2021</u> , CDPHE will have an increase in expenditures of \$186,168 in state fiscal year 2021-22 and \$171,226 in state fiscal year 2022-23.

Bill Summary

Under current law, the Office of Health Equity in the Department of Public Health and Environment (CDPHE) administers the Health Disparities Grant Program. The grant program is funded from the Health Disparities Grant Program Fund, which receives a portion of annual cigarette and tobacco tax revenue. This bill renames the program as the Health Disparities and Community Grant Program and expands its functions. The program's grant making scope is broadened to address social determinants of health for underrepresented populations. In addition, the bill specifies that the program fund may receive appropriations from the General Assembly, and requires the office to develop grant application criteria for community organizations seeking grant funding.

The bill expands the makeup of the Health Equity Commission by adding representatives of five state agencies. In addition, the bill directs the office to facilitate a state agency work group by July 1, 2022, consisting of the agencies represented on the commission, to develop an Equity Strategic Plan to coordinate state agencies' work in addressing social determinants of health disparities. Every two years, starting January 1, 2022, the office must issue a report on health disparities in Colorado by race and ethnicity that includes an assessment of social determinants of health and recommends strategies to address inequities. The bill directs state agencies to use the report in their strategic planning processes.

Issue Summary

Health Disparities

Health disparities are inequities in the quality of health, health care, and health outcomes experienced by groups based on social, racial, ethnic, economic, and environmental characteristics. Many factors contribute to health disparities, including genetics, access to care, quality of care, community features (e.g., inadequate access to healthy foods, poverty, limited personal support systems, and transportation), environmental conditions (e.g., poor air quality), language barriers, and health behaviors. The social, economic, and environmental conditions where people live, learn, work and play are known as social determinants of health.¹ Health disparities account for significant costs to states and communities. According to a 2018

¹ National Conference of State Legislatures, "Health Disparities Overview", November 16, 2020.
<https://www.ncsl.org/research/health/health-disparities-overview.aspx>

study, health disparities cost \$42 billion in lowered productivity and \$93 billion in excess medical costs each year.² Additionally, those without access to health insurance and affordable care most often turn to emergency care, which is much more costly than primary care, preventative measures and care management.³

Health and health care disparities manifest across a broad range of dimensions (e.g. socioeconomic status, age, geography, race, ethnicity, language, disability status, citizenship status, gender identity, and sexual orientation) and these groups are not mutually exclusive.³

BIPOC Health Disparities

Health and health care disparities manifest across racial and ethnic groups, particularly in poorer outcomes for Black, Indigenous, and People of Color (BIPOC) when compared with whites.³ American Indians and Alaska Natives and Blacks have higher rates of reported health issues than whites, such as diabetes, asthma, AIDS and HIV diagnoses, and death rate. Infant mortality rates are higher for Blacks and American Indians and Alaska Natives compared to whites, and Black males have the shortest life expectancy compared to other racial groups.³ Additionally, Blacks have higher rates of heart disease, diabetes, and hypertension than other groups, and Black children have a 500% higher death rate from asthma compared with white children.⁴ Hispanics have higher rates of obesity than non-Hispanic whites.⁵ Additionally, there are disparities within the ethnicities that make up the Hispanic group.⁵ For example, Puerto Ricans suffer disproportionately from asthma, HIV/AIDS, and infant mortality. While, Mexican Americans suffer disproportionately from diabetes.⁵

As the U.S. and Colorado population continues to become more racially and ethnically diverse, it becomes increasingly necessary to address health disparities for BIPOC communities.³ These disparities have developed within the context of the U.S.'s historical, political and social relationship with racial and ethnic diversity. Addressing the links between racism and poor health will be key to beginning to create health equity for BIPOC communities.⁶ Discrimination, including racism, can lead to chronic and toxic stress and shapes social and economic factors that make it difficult for racial and ethnic minority groups to fulfil health care best practices.⁷

Food Insecurity. In 2019, nearly 1 in 10 Coloradans (9.6%) reported food insecurity, or not having enough food due to limited financial resources. Compared to their food-secure counterparts, Coloradans who experienced food insecurity were 3.9 times more likely to report poor mental health, 3 times more likely to report fair or poor oral health, and 3.2 times more likely to report fair or poor general health.⁸

Enduring structural inequalities and discrimination in transportation, housing and employment have created racial and ethnic disparities in food insecurity, even when controlling for economic factors.⁵ BIPOC communities experience much higher rates of food insecurity than whites.⁵ 22.2% of Black Coloradans and 14.0% of Hispanic Coloradans reported food insecurity in 2019, compared with just 7.7% of whites⁵. In 2019, older adults (ages 65+) of color were three times more likely than older white adults (16% to 5%) to report

² Altarum, "The Business Case for Racial Equity: A Strategy for Growth", April 24, 2018. <https://altarum.org/RacialEquity2018>

³ Kaiser Family Foundation, "Disparities in Health and Health Care: Five Key Questions and Answers", March 4, 2020.

<https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/#:~:text=A%20E2%80%9Chealth%20disparity%E2%80%9D%20refers%20to,care%2C%20and%20quality%20of%20care>

⁴ Harvard T.H. Chan School of Public Health, "Health disparities between blacks and whites run deep", 2021.

<https://www.hsph.harvard.edu/news/hsph-in-the-news/health-disparities-between-blacks-and-whites-run-deep/>

⁵ U.S. Dept. of Health & Human Services, Office of Minority Health, "Profile: Hispanic/Latino Americans", 2021.

<https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=64>

⁶ Harvard T.H. Chan School of Public Health, "Race and Health", 2021. <https://www.hsph.harvard.edu/race-and-health/>

⁷ Centers for Disease Control and Prevention (CDC), "Health Equity Consideration and Racial and Ethnic Minority Groups", Feb. 12, 2021.

<https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html>

⁸ Colorado Health Institute, "An Uneven Burden: Food Insecurity in Colorado", July 17, 2020.

<https://www.coloradohealthinstitute.org/research/uneven-burden-food-insecurity-colorado>

eating less than they felt they should because there was not enough money for food in the past 12 months.⁹ In Larimer County, the Health District of Northern Larimer County's 2019 Community Health Assessment found that 17% of Hispanic or Latinx respondents reported, in the past year, usually or always worrying about having enough money for food, compared to 8% of white/non-Hispanic respondents.¹⁰

Health care access and utilization. People from some racial and ethnic minority groups are more likely to be uninsured than whites. Health care access can also be limited for these groups due other factors besides insurance coverage, such as lack of transportation or child care; communication and language barriers; cultural differences between patients and providers; and historical and current discrimination in healthcare systems.^{6,11} Some people from racial and ethnic minority groups may hesitate to seek care because they distrust the government and health care systems responsible for inequities in treatment and historical events, such as the Tuskegee Study of Untreated Syphilis in the African American Male and sterilization without permission.⁶ Additionally, among nonelderly adults, American Indians and Alaska Natives, Blacks, and Hispanics are more likely than whites to delay or forgo needed care. Nonelderly Hispanic and Black adults are less likely than their white counterparts to have been seen by a medical or dental provider in the past year or to have a usual source of care.³

Educational, income, and wealth gaps. Inequities in access to high-quality education for some racial and ethnic minority groups can lead to lower high school completion rates and barriers to college entrance. This may limit future job options and lead to lower paying or less stable jobs. People from some racial and ethnic minority groups are disproportionately represented in health care facilities, farms, factories, grocery stores, and public transportation workforces. People with limited job options likely have less flexibility to leave jobs that may put them at a higher risk of exposure to illnesses, limited financial capacity to miss work if they are sick, as well as are less likely to be provided with paid sick days.⁶ In addition, disproportionate unemployment rates for some racial and ethnic minority groups may lead to greater risk of eviction and homelessness.⁶

Disabilities and Health Disparities

Health and health care disparities manifest across communities characterized by one or more disabilities. 61 million adults in the U.S. (26% of the U.S. population) live with some form of disability, as relates to mobility, cognition, independent living, hearing, vision, or self-care capacities.¹² Compared to non-disabled adults, adults living with a disability are 12% more likely to have obesity, 14.8% more likely to smoke, 7.7% more likely to have heart disease, and 9.1% more likely to have diabetes. Adults with disabilities also face significant barriers to health care access. Among the disabled nonelderly adult community, 1 in 3 do not have a usual health care provider and 1 in 3 have an unmet health care need due to cost in the past year. Further, a quarter of adults with disabilities between the ages of 45-64 years did not have a routine check-up in the past year.¹²

The disabled community is incredibly diverse and has a wide array of needs. A person can have just one disability or multiple. Disability has three dimensions – (1) impairment in bodily structure or function, or

⁹ Colorado Health Institute, "Racial and Ethnic Health Disparities Lead to Worse Health Outcomes Among Colorado's Aging Population", April 22, 2021. <https://www.coloradohealthinstitute.org/research/racial-and-ethnic-health-disparities-lead-worse-health-outcomes-among-colorados-aging>

¹⁰ Health District of Northern Larimer County, "2019 Community Health Assessment", 2020. <https://www.healthdistrict.org/2019-community-health-assessment>

¹¹ Harvard T.H. Chan School of Public Health, "Racial Disparities in Health Care: Justin Dimick and Coauthors' June Health Affairs Study", June 4, 2013. <https://blogs.sph.harvard.edu/ashish-jha/2013/06/04/racial-disparities-in-health-care-justin-dimick-and-coauthors-june-health-affairs-study/>

¹² Centers for Disease Control and Prevention (CDC), "Disability and Health Promotion", Sept. 16, 2020. <https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html>

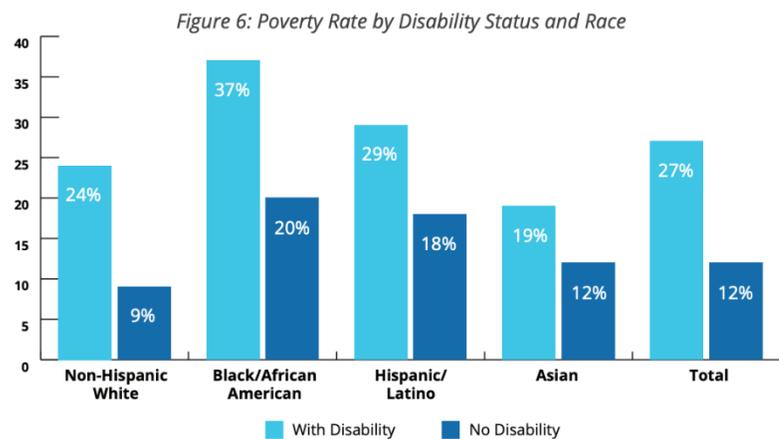
mental functioning; (2) activity limitation, or difficulty seeing, walking, hearing, or problem solving; and (3) limited capacity to participate in daily activities (e.g. working, obtaining care, socializing)

Prohibitive costs. Americans living with disabilities utilize significantly more health services and spend much more out-of-pocket for medical care than their non-disabled counterparts. Disabled Americans have health care expenditures that are approximately 5 to 6 times that of non-disabled Americans.¹³

Limitations in care accessibility. Although Americans living with disabilities are more likely to have insurance than non-disabled Americans, the disabled communities report a wide range of obstacles in obtaining care, such as maintaining a usual care provider, accessing timely and routine medical care, and obtaining specialty services such as home care, rehabilitation, and/or medical equipment.⁹ Studies have also shown that disability services are frequently unavailable, especially in rural areas.¹⁴

People with disability were four times more likely to report maltreatment by medical providers, more than twice as likely to report that medical providers did not have sufficient skills to meet their needs, and nearly three times more likely to report being denied care.¹⁰

The social service system in the U.S. treats disability and poverty (which is more prevalent among BIPOC communities) separately. For example, those who wish to qualify for anti-poverty programs often must prove they are employed, but to qualify for disability benefits (including health coverage) applicants typically must prove they are not capable of working. Consequently, disabled individuals who are trying to emerge from or avoid poverty face systemic challenges.¹⁵



Physical barriers & transportation limitations. Inadequate and/or limited transportation options, inaccessible parking areas, narrow doorways, poor signage, inadequate bathroom facilities and inaccessible medical equipment create barriers to health care facilities. For example, mammography equipment only accommodates women who are able to stand, and women with mobility limitations are often unable to access such breast cancer screening since examination tables are typically not height-adjustable.⁹

LGBTQ+ Health Disparities

LGBTQ people experience several health disparities¹⁶. In terms of behavioral health, the LGBTQ population is at greater risk for mood disorders and anxiety, suicide and suicidal thoughts, and eating disorders, as well as tobacco, alcohol and other substance abuse¹⁷. In terms of physical health, the LGBTQ population reports

¹³ U.S. National Library of Medicine, "Disparities in Insurance Coverage, Health Services Use, and Access Following Implementation of the Affordable Care Act: A Comparison of Disabled and Non-disabled Working-Age Adults", Jan 2017. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5798675/>

¹⁴ World Health Organization (WHO), "Disability and Health", Dec 1, 2020. <https://www.who.int/news-room/fact-sheets/detail/disability-and-health>

¹⁵ National Disability Institute, "Financial Inequality: Disability, Race and Poverty in America", Feb 2019.

<https://www.nationaldisabilityinstitute.org/wp-content/uploads/2019/02/disability-race-poverty-in-america.pdf>

¹⁶ Cigna, "LGBT Health Disparities", Feb 2017. <https://www.cigna.com/individuals-families/health-wellness/lgbt-disparities>

¹⁷ National Center for Transgender Equality, "National Transgender Discrimination Survey: Full Report", Sept 11, 2012.

<https://transequality.org/issues/resources/national-transgender-discrimination-survey-full-report>

more chronic conditions and are more likely than other groups to rate their health as poor¹⁸. They are also more likely to be obese and have higher rates of HPV infection¹⁹. Lesbian and bisexual women have higher rates of breast cancer and cervical cancer^{15, 20}. Gay and bisexual men are more likely to have HIV/AIDS and have anal cancer^{15 21}.

Despite such higher rates of worse health outcomes, LGBTQ populations face significant barriers in accessing health care¹³. LGBTQ people are less likely to have health insurance and fill prescriptions. They are also more likely to delay getting care or to obtain care in emergency rooms¹³. Additionally, the LGBTQ population is more likely to be refused health care services or to be harassed by health care providers than their non-LGBTQ counterparts¹³. Stigma, lack of healthcare providers' awareness, and insensitivity to the unique needs of this community perpetuate poor health service provision to LGBTQ people as well as their reluctance to seek medical care²².

LGBTQ Health Disparities in Colorado²³

Between 2011 and 2018, the percentage of uninsured LGBTQ Coloradans has dropped from 10% to 5%. However, 32% still report lack of choice and access to LGBTQ-competent providers who are in-network with their insurance provider. Additionally, 25% of LGBTQ Coloradans report that their medical insurance is not sufficient for themselves and their dependents. In 2017, 36% of LGBTQ people cited cost as the reason they did not seek health care for, compared to just 12.9% of the general public. The LGBTQ population is also hesitant to come out to their health care providers – 43% of LGBTQ Coloradans do not reveal their sexuality to their providers, mainly due to fears that their providers are not supportive of and would discriminate against LGBTQ people. Also, in regard to behavioral health, the LGBTQ Colorado community are almost three times more likely to have ever been diagnosed with depression and more than three times more likely to have ever been diagnosed with depression than their non-LGBTQ counterparts. Overall, LGBTQ Coloradans are three times more likely than non-LGBTQ Coloradans to say that their mental health is not good, in addition to reporting worse physical health outcomes. LGBTQ Coloradans who have LGBTQ-friendly or LGBTQ-competent providers are 22% more likely to have seen a primary care provider in the last 6 months and 26% more likely to have received a physical or wellness exam in the past year.

Office of Health Equity

The Office of Health Equity, housed within the Colorado Department of Public Health and Environment, is focused on building partnerships to mobilize community power and transform systems to advance health equity and environmental justice. The Office was codified in statute through Senate Bill 242 in May 2007, and, in 2013, its service scope was extended to include lesbian, gay, bisexual and transgender (LGBT), aging, disabled, low-socioeconomic and geographic populations.²⁴ The Health Equity Commission, also created by Senate Bill 242 in May 2007, advises the Office of Health Equity on health equity issues, focusing on

¹⁸ U.S. National Library of Medicine, "Minority Stress and Physical Health Among Sexual Minorities", Sept 2011.

<https://pubmed.ncbi.nlm.nih.gov/26173210/>

¹⁹ National LGBT Cancer Network, "HPV and Cancer", 2021. <https://cancer-network.org/cancer-information/hpv-and-cancer/>

²⁰ Women's Health Issues, "Comparing breast cancer risk between lesbians and their heterosexual sisters", March 2004.

[https://www.whijournal.com/article/S1049-3867\(04\)00018-0/abstract](https://www.whijournal.com/article/S1049-3867(04)00018-0/abstract)

²¹ Centers for Disease Control and Prevention (CDC), "Sexually Transmitted Diseases: Gay, Bisexual and Other Men Who Have Sex with Men" March 30, 2021. <https://www.cdc.gov/std/life-stages-populations/msm.htm>

²² U.S. National Library of Medicine, "Health Care Disparities Among Lesbian, Gay, Bisexual, and Transgender Youth: A Literature Review", April 2017. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5478215/>

²³ One Colorado Education Fund, "Closing the Gap: The Turning Point for LGBTQ Health", June 2019. <https://one-colorado.org/wp-content/uploads/2020/06/Closing-the-Gap.pdf>

²⁴ Colorado Department of Public Health and Environment, "About the Office of Health Equity", 2021. <https://cdphe.colorado.gov/about-office-health-equity>

those inequities. The office must collaborate with the Health Equity Commission, community partners working on health equity, local public health agencies, stakeholders from affected communities, data organizations, and other state and local partners in the creation of the report. Each state agency that is represented on the Commission shall use the report. In subsequent reports, after the first, the Office shall report progress to address social determinants of health and strategies used to address health disparities and inequities.

Within six months of the publication of the first report, the Governor is to convene the Commission to conduct a strategic planning process and develop an equity strategic plan that responds to the report and ensures that there is coordination in equity-related work across state agencies. The process must include input from both community stakeholders and policymakers. The Office can collaborate with the grant program to address issues identified by the strategic plan. Each member of the Commission that represents a state agency must develop a plan to address the social determinants of health relevant to the agency and dedicate up to 20 hours of staff time to the development and implementation of the strategic plan.

Health Equity Commission

The bill adds the following state agency officials (or their designee) to the Commission:

- Executive Director of the Department of Labor and Employment
- Executive Director of the Department of Local Affairs
- Executive Director of the Department of Transportation
- Executive Director of the Department of Public Safety
- Commissioner of Education of the Department of Education
- Executive Director of the Department of Corrections
- Executive Director of the Department of Higher Education

Effective Date

The bill is effective upon the Governor's signature or if the Governor allows it to become law without their signature.

Fiscal Note

CDPHE will have an increase in expenditures of \$186,168 in state fiscal year 2021-22 and \$171,226 in state fiscal year 2022-23. These costs are for staff to support the agency work group, conduct outreach, and prepare the office's biannual report. The fiscal note assumes that General Fund will be appropriated to the Health Disparities Grant Program Fund to cover these costs. If

Table 2
Expenditures Under SB 21-181

	FY 2021-22	FY 2022-23
Department of Public Health and Environment		
Personal Services	\$118,709	\$118,709
Operating Expenses	\$2,025	\$2,025
Capital Outlay Costs	\$12,400	-
Centrally Appropriated Costs ¹	\$53,034	\$50,492
Total Cost	\$186,168	\$171,226
Total FTE	1.5 FTE	1.5 FTE

¹ Centrally appropriated costs are not included in the bill's appropriation.

General Fund is not provided, then less funding will be available for health disparity grants.

Reasons to Support

By ensuring that Health Equity Commission will now include members from the state departments of corrections, transportation, education, local affairs, etc. this bill ensures the council structurally mirrors the various characteristics and roots of health disparities. Engaging all of these departments and requiring them to initiate and implement strategies for health equity relevant to their own, individual departments will help promote structural change towards realizing health equity within each department's purview. The bill has a very comprehensive approach to coordinating such structural change across the entire state government, which will help to facilitate big picture, state-wide developments toward decreasing health disparities. Additionally, the fiscal note seems sufficient to cover the breadth of additional responsibilities within the Office of Health Equity. The reports that the Office will now be required to publish will be an important, transparent accountability tool for the Office and its additional funds, as well as an effective means of evaluating health disparities across the state.

Supporters

- AARP
- Biogen
- Children's Hospital Colorado
- Colorado Academy of Family Physicians
- Colorado Association of Local Public Health Officials
- Colorado Association for School-Based Health Care
- Colorado Behavioral Healthcare Council
- Colorado Children's Campaign
- Colorado Community Health Network
- Colorado Nonprofit Association
- Colorado Cross-Disability Coalition
- Disability Law Colorado
- Easterseals Colorado
- Florence Crittenton Services
- Immunize Colorado
- League of Women Voters of Colorado
- Mental Health Colorado
- Sanofi
- The Arc of Colorado

Reasons to Oppose

There is a lack of community engagement and voice at the table to help inform the strategic plan and prioritize community needs. The funding could detract financial resources from more direct efforts to revitalize the state economy after COVID-19.

Opponents

- No opposition has been made public at this time.

Other Considerations

Will this approach be effective enough, or too ambitious, to actually create policy and systems change?

About this Analysis

This analysis was prepared by Health District of Northern Larimer County staff to assist the Health District Board of Directors in determining whether to take an official stand on various health-related issues. The Health District is a special district of the northern two-thirds of Larimer County, Colorado, supported by local property tax dollars and governed by a publicly elected five-member board. The Health District provides medical, mental health, dental, preventive and health planning services to the communities it serves. This analysis is accurate to staff knowledge as of date printed. For more information about this analysis or the Health District, please contact Alyson Williams, Policy Coordinator, at (970) 224-5209, or e-mail at awilliams@healthdistrict.org.