

**Mayor Linda Gorton’s Commission on Racial Justice and Equality
Health Disparities Subcommittee Recommendations**

Co-Chairs

- Dr. Tukea Talbert, DNP, RN, CDP (Assistant Operations Executive, UK HealthCare)
- Dr. Lovoria B. Williams, PhD, FNP-BC (Associate Professor, University of Kentucky (UK) College of Nursing)

Committee Members and affiliations

Name	Affiliation
Kacy Allen-Bryant, MSN, RN	UK College of Nursing; Lexington-Fayette County Department of Health
Dr. Adu Boateng	Psychologist
Dr. Mara Chambers	UK HealthCare
Dr. Jai Gilliam	Baptist Health
Michael Halligan	God’s Pantry Food Bank
Mark Johnson	Public Health Advocate
Timothy Johnson	United Way of the Bluegrass
Vivian Lasley-Bibbs	KY Dept. of Public Health Office of Health Equity
Rabbi Shlomo Litvin	Chabad of the Bluegrass
Stephen Overstreet	Youth Advocate
Hon. Kathy Plomin	Lexington Fayette County Council Member
Dr. Brandi White, PhD, Assistant Professor	UK Health Services Center

Meeting dates

July 7, July 15, July 22, July 29, and August 19 with an overall attendance of 84%.

Health Disparities Committee Objective

The overall objective of the Health Disparities Subcommittee is to identify the most significant systemic factors that lead to disparate health outcomes among Black and Indigenous People of Color (BIPOC) and make recommendations to dismantle those factors caused by structural racism. The Subcommittee adopted the overarching goals of the Health Equity Framework to demonstrate upstream social factors downstream impacts such as health status, mortality, morbidity, and life expectancy.

Purpose Statements

1. Clearly promote our priority and commitment to intentionality in addressing all forms of health and health care inequities.
2. Provide a roadmap to operationalize our recommendations to address racial healthcare inequities
3. Identify measurements to track health outcomes and changes in the contributing factors that influence outcomes.
4. Intentional measurement of assets and identification of gaps and challenges.
5. Authentically and intentionally, collaborate and communicate with communities to co-create solutions to inequities based on individual’s lived experience and knowledge of the community and the challenges.

6. Create a venue for partner organizations and the Lexington Fayette County Government to improve their practice, knowledge and skills to advance and elevate health equity.
7. Foster trust between communities of color and Lexington-Fayette County government.

Acknowledgements of root causes and power dynamics: **Power, Privilege, & Access**

- At the root of health inequities is a power imbalance in who shares the decisions that impact health
- Recognize the need to develop more power within and together with communities of color in Lexington- Fayette County
- Invest the appropriate time to remove the reasons People of Color (POC) are under-represented in decision-making that impacts the following barriers:
 - Historic and contemporary discrimination
 - Language and cultural barriers
 - Limited availability for health promotion activities
 - Lack of exposure & knowledge regarding public policy
 - Past lived experiences of trust breaches

Common Language

- **Equality-** *everyone is provided the same amount of resources.*
- **Equity-** *providing the amount of resources proportionate to what is actually needed. To eliminate the disparities in health, wealth, opportunities and resources, the communities that have experienced persistent structural barriers to equity are given more.*
- **Health Equity-***when all people and communities have the opportunity to attain their full potential and highest level of health.*
- **Health Disparities-** *differences in health among socially-disadvantaged racial/ethnic groups and economically disadvantaged people within any racial/ethnic group. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic -status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. Healthy People, 2020*
- **Social Determinants of Health-** (SDoH) *conditions in which an individual lives, learns, works, plays, and age that affect their ability to achieve health. SDoH, comprise up to 80% of the factors affecting health outcomes and reflect broader social and economic inequities that are rooted in cross sector structural and systemic barriers as well as underlying racism and discrimination.*

Data and Reports Used:

- Robust feedback from subcommittee members
- Review and discussion of historical documents
- Anecdotal reports from key community stakeholders

- Additional meetings with stakeholders to gain more insight on community climate and needs
- Additional meetings to further explore data pools/resources to identify metrics of success
- Community Health Assessment (CHA) report, Community Health Assessment Improvement Plan (CHIP), Healthy People 2020
- The key Social Determinants of Health reviewed included all areas but focused predominantly on neighborhood & physical environment, food, community & social context, and the health care system
- Kentucky Minority Health Status Report

Documents Reviewed

I. Documents reviewed included:

- Community Health Assessment (2016)
- Community Health Assessment Health Improvement Plan (2016-2021)
- Community Health Assessment & Health Improvement Plan Progress Report (2018 & 2019)

II. Key information/themes identified

- Compassion and equity with care delivered
- Access to care (transportation, proximity of services, general access to providers, coverage)
- Lack of navigation to ensure awareness and access to services
- Uninsured less likely to have primary care providers & receive less preventive care, dental care, chronic disease management, & behavioral health counseling
- Lack of access results in care delays, preventable hospitalizations and unmet health needs
- Workshop for providers on LGBTQ+ issues and provider sensitivity to transgender medical care needs (new trends, medicinal support)
- Access to fresh fruit/vegetables
- Mental health (assessment, misdiagnoses, and healthcare provider/patient racial/ethnic concordance)
- Qualitative data was more prominent than quantitative data in most reports

Assessment of documents

- The strength of the documents is their rich, qualitative information and ability to demonstrate the need for additional quantitative data to guide the development of policy changes. Moreover, the documents indicated the need for a standard language to quantify the Lexington's health disparities
- Challenges: lack of county-level health quantitative data and a more solid process to follow-up on CHIP and outcomes.
- Quantitative data sets were requested and currently no unique data sources are used locally for quantifying population health and especially health disparities.

Guiding Framework for Recommendations

Framework for Health Equity and the Social Determinants of Health (SDoH) from the Kaiser Family Foundation

- Reviewed both the Socio-Ecological Model along with the Medical Model so that we included upstream and downstream factors associated with health disparities
- The four major social determinants addressed by the subcommittee are:

1. **Food**- e.g. food access and availability
2. **Community and social context**, e.g. support systems, community engagement, medical mistrust
3. **Neighborhood and physical environment**, e.g. transportation, walkability, green space
4. **Health Care System**, e.g. provider availability and cultural competency

Overarching Problem Statement

Currently there are no sustainable or standard process to measure, monitor and report health disparities based on race and ethnicity nor are there impact measures. Consequently, health inequities are not quantifiable and there is a dearth of data to guide the strategies to affect policy and infrastructure changes necessary to adequately address the issues which negatively impact the health outcomes of black and indigenous people of color (BIPOC).

Recommendations

Immediate Action- within 60 days

Intermediate Action- within 60-90 days

Long-term- within 90-120 days

Problem Statement

Data indicates a lack of community awareness of health-related resources and a lack of culturally competent healthcare providers, which contributes to mistrust of the healthcare system. Evidence indicates that Community Health Workers (CHWs)/Promotoras are uniquely positioned to build trust and address the barriers faced by traditionally underserved communities when seeking medical care and services.

Recommendation #1 Community Health Worker Role

The CHW will be a layperson with at least a high school diploma who lives in one of the areas that experience disparate health outcomes e.g. East or West End

Recommended immediate actions:

- Hire fulltime CHW by the local hospital system
- CHW Duties:
 - Serve as a liaison between the Mayor's office, community residents and hospitals
 - Navigator to health services
 - Maintain documentation and reporting
 - Foster aggressive culturally appropriate communications campaigns regarding health related matters, e.g. COVID-19 response and recovery, testing, vaccine, Easy 1-2-3 insurance, research opportunities that may provide precision medicine outcomes for people of color, etc.
 - Leverage technology to communicate health information e.g. text messaging, calling posts
 - Coordinate neighbor-hood based services, e.g. periodic mobile services to the affected communities mobile screenings, mobile food markets, and placed based services

- Advocate for expanded clinic hours to accommodate the schedules of community members
- Review health messaging with Lexington-Fayette County Health Department (LFCHD) Community Advisory Board to ensure targeted messaging to the community

Recommended intermediate actions:

- Foster relationships with additional potential community partners e.g. health centers, recreation centers, social organizations, community members, to assist with community outreach efforts
- Collect data to support benchmarks and metrics of success e.g. number of referrals
- Seek funding: Potential funders: Robert Wood Johnson Foundation, Healthy Kentucky Foundation

Recommended long-term actions:

- Explore options to strengthen and support the CHW Promotoras (CHW/P) workforce
- Partner with KY Health Department for Public Health to ensure standardized continuing education options through partnering with Laura Eirich or designee over the Community Health Worker Program (Laura.eirich@ky.gov or 502-564-7996 ext. 4437)
- Register all CHW/P with the KY Health Department to ensure access to training and continuing education opportunities
- Use CDC's Policy Evidence Assessment Report ([PEAR](#)) to identify best policies and practice that can support the efficacy of CHW/Ps
- Explore potential methods to leverage the efforts of CHW/P's and the Paramedicine program through ride-alongs or job shadowing with Paramedicine Team to improve the understanding of the services the Paramedicine Team provides in the community. This may assist with appropriate access and navigation to this service by CHW/Ps

Necessary partnerships/ Structure

- University College of Nursing to provide certified Community Health Worker training
- Markey Cancer Center to provide mobile cancer screenings
- Lexington Housing Authority to recommend a resident to serve on the Community Advisory Board and as point to contact for the CHW
- Faith-based settings:
 - Serve as sites for and facilitates mobile health screenings, vaccinations, etc.
 - Disseminate health messaging
 - Nominate a liaison (direct contact) to serve as a bridge to the church members and the CHWs
- Local hospitals to support the salary and continued training of the CHW/Ps
- CHW/Ps supported by trained community volunteers

Problem Statement

Currently there are no methods to adequately address issues related to food insecurity. The issue is multifaceted in that the current food system does not consistently address widespread food insecurities experienced by residents of the most at-risk neighborhoods. Moreover, there

are no consistent opportunities to obtain public input on solutions or use underrepresented businesses as part of the solution to provide food options and increase accessibility of healthy food options. Other root causes of food insecurity include transportation challenges, regulation and allocation of SNAP and proximity of food retailers to communities of color.

Recommendation #2 Improve Food Access & Healthy Food Options

- Adopt the mission of the Supplemental Nutrition Assistance Program (SNAP), which is “To increase food security and reduce hunger by providing children and low income individuals access to food, a healthy diet and nutrition education in a method that supports American agriculture, locally grown produce, and inspires public trust and confidence.”

Recommended immediate actions:

- Expand current options for mobile food distributions that includes a model similar to that in Louisville, KY (Dare to Care-Mobile Market)
<https://www.whas11.com/article/news/community/dare-to-care-mobile-market-returns-louisville/417-0eede9f1-be0e-4ede-8c99-9136c4db226f>
- Establish a regularly scheduled weekly Mobile Market to various locations based on need determined by data (e.g. zip code report of food insecurities)
- Explore opportunities to strengthen mobile food distributions in terms of publicized routes and schedules

Recommended intermediate action:

- Explore the possibility of working with local Uber options and/or taxi services to provide transportation to proximal markets for food access

Recommended long-term actions:

- Create a process of annual assessment of SNAP eligible retailers and their locations relative food deserts/insecurities: Assessment to include:
 - the number of co-location status and need for access status that do not meet SNAP criterion A or B but are located in areas where SNAP clients have significantly limited access
 - the number of SNAP clients vs. the number of people eligible;
 - the number of SNAP retailers and average radius to clients, and the last review of the retailer by the Office of Inspector General (OIG)
 - the number of complaints launched against the retailer and reports of fraud in a report by zip code
- Development of a Community Advisory Board (co-led by Michael Halligan and Stephen Overstreet) to conduct routine focused assessments on food availability, options, & access similar to the suggested process at this link ([food questionnaire](#))

Partnerships for Food Access:

- Mayor’s Office Ashton Potter-Wright: Director of Local Food & Agricultural Development

- Strengthen and expand relationship and presence of Black Soil (<https://www.blacksoil.life>) and other minority owned businesses that could participate in communities of color either by donating funds and/or produce for use by SNAP eligible retailers
- Strengthen and continue KY Double Dollars Program for WIC Farmer's Market Nutrition Program and Senior Farmer's Market Nutrition Program
- Partner with local hospitals to ensure that patients discharged from hospitals with food insecurities are connected to food resources and assessed for SNAP eligibility
- Create a repository of Minority Owned Businesses that could participate in Community Farm Alliance and of Bluegrass Farm to Table initiatives
- Follow-up and reassess the feasibility of Better Bites/Fresh Market via Tweens Coalition
- Partner with community planners/development for future addition of food establishments/markets/grocery stores so that food deserts are targeted as a priority for placement/construction with the caveat that they would be required to meet SNAP standards
- Continue and strengthen alliance with Community Farm Alliance –Becca Warta(Becca@cfaky.org)
- LFCHD Community Advisory Board and other identified stakeholders to develop solutions to address food deserts (ideal community partners: Steven Overstreet & Michael Halligan with God's Pantry)

Food Policy Recommendations

- Require each SNAP participating retailer to post signage denoting their acceptance of SNAP along with contact information to launch complaints regarding client's experience and quality of produce: USDA Office of Inspector General; P.O. Box 23399; Washington, DC 20026-3399; or call 800-424-9121; 202-86-9984 or 202-690-1202(TDD); on-line electronic site- <https://www.usda.gov/oig/hotline.htm>
- Review each SNAP retailer annually for compliance with SNAP criteria especially retailers with complaint(s); Annual and/or routine reviews should be unannounced and appropriate documentation of the outcomes should be maintained by the OIG
 - OIG should to establish a process that removes retailer's SNAP privileges if they are found noncompliant or have an identified number of complaints and/or trends of noncompliance
 - Ensure that co-location: multiple firms operate at same location to meet criteria elements, Food and Nutrition Services will consider single firm when determining SNAP authorization; and need for access sites: stores that do not meet criterion A or criterion B but still considered for authorization if in an area where SNAP clients have significantly limited access
- Routine review of SNAP requirements-the last enhanced requirements were effective January 17, 2018 (there should be a required timeframe for consistent re-assessment of program requirements based off of best practices/industry standards)

Problem Statement

Currently the transportation options are inefficient for individuals without personal vehicles. Data indicates barriers to accessing healthcare related to transportation challenges, such as multiple bus transfers with resultant long bus ride to and from medical appointments and prolonged work absences to obtain medical care. Moreover, the Wheels Paratransit is currently limited to individuals with disabilities and long wait times when using Wheels

Paratransit. <https://lextran.com/accessibility/wheels-paratransit/>

The inefficiency ranges from long bus rides to healthcare and other critical appointments (e.g. job interviews, work, etc.). Due to limited routes, lengthy rides, and restrictions and guidelines for using Wheels Paratransit, individuals are often challenged to comply with medical appointments, job interviews, etc. This inefficiency also affects their work time absence, potential employability and ability to maintain employment.

Recommendation #3: Improve Transportation Services

Recommended immediate action:

- Expand Lextran Wheels Paratransit medical transit-line to run either through the medical districts or to provide door-to-door transportation for individuals with low socioeconomic status
- Partner with private rideshare services such as UberHealth for direct pick-ups and drop-offs for medical appointments and pharmacy (<https://www.uber.com/blog/health/>)

Problem Statement

Currently there are no data that monitors, reports, or incentivize a diverse healthcare workforce. As a result, individuals in communities of color have limited choices to obtain healthcare from providers that reflect their image or cultural background. The lack of physician patient concordance has potential negative impact on healthcare outcomes, misdiagnoses, mistreatment and/or treatment omissions. Other potential issues include patients not being seen as unique individuals, listened to, or understood, which affects healthcare quality and safety.

Recommendation #4 Improve Cultural Competence/ Provider-Patient Congruence

Recommended immediate action:

- Cultural competence training for all Lexington-Fayette County employees to include Mayor's office
- Influence local healthcare settings to hire diverse staff

Recommended intermediate action:

- Influence local healthcare providers to require cultural competence training
- Patient satisfaction survey from each local healthcare provider's office that includes items specific to cultural competence
- Develop metrics to provide a graded scoring system as an incentive for healthcare sites that meet certain cultural competency standards e.g. diversity of staff/providers, completion of cultural competency by all staff, ability for patients to choose clinician based on preferences.
 - Have each healthcare site post the grade in their office similar to restaurant inspections

Partnerships

- Support pipeline programs

- Black Male Working (BMW) and UK College of Medicine Pipeline Program through development of yearly scholarship for minimum of one student accepted to medical school with requirement to remain in Fayette County post graduate for defined period
- Develop and support UK College of Nursing Nurse Practitioner Program through similar BMW scholarship program
- Explore pipeline relationship with College of Health Sciences, Pharmacy, etc.
- Explore other pipelines offered through the Institute for Diversity and Health Equity Summer and Fall Enrichment Programs

Problem Statement

Currently there are no tracking methods or metrics of community health outreach activities e.g. COVID-19 testing, therefore it is impossible to determine whether the priority communities are reached/served by the event or determine the impact of the event.

Recommendation #5: Strengthen County Government & CHIP Work Group Collaboration

Develop a structured collaboration between the Mayor's Office and the Lexington Fayette County Health Department (LFCHD) Community Health Improvement Plan (CHIP) Work Group- to serve as the overseer of the recommendations of the Health Disparities Subcommittee.

Recommended immediate actions:

- Build on the data collected by the LFCHD's Community Health Assessment and Improvement Plan (CHIP) to monitor and track the progress and impact of the Mayor's Health Disparities Subcommittee. The CHIP document reviews current health trends through multiple sets of lenses. LFCHD uses the information derived from the community health assessment to inform decision-making for community engagement and partnerships.
- CHIP will develop data metrics necessary to provide an annual county-level Minority Health Status Report card on health outcomes, e.g. diabetes, obesity, asthma, cardiovascular disease, preventative screenings, mental health, risk behaviors, cancer, morbidity, mortality, hospital length of stays, readmits, ER visits, etc.
 - Data will be used to drive the allocation of health care resources

Recommended intermediate actions:

- CHIP to work in concert with LexBeWell to report and develop additional strategies to address the data derived from the Community Health Assessment
- Require minimum data collection for all community health outreach activities :
 - Age
 - Gender
 - Race/ethnicity
 - Zip code
 - Insurance status Yes/No

- LFCHD to oversee health related community outreach to the affected communities e.g. COVID-19 screening &, vaccines, flu vaccines Immediate Action: LFCHD to oversee all data collection for community outreach events
- Continue the Community Needs Assessment (formerly Community Health Assessment-CHA) for qualitative data every five years and use the data as a metric of community perceptions on the impact of the Mayor’s Racial Commission on Justice & Equality
- Develop a Community Advisory Board comprised of lay citizens from each affected community. Justification: Data suggest a lack of trust and feelings of marginalization among communities of color. The Community Advisory Board will work closely with the Fayette County Health Department & CHIP to develop solutions to health disparities
 - Consider the relevance of annual insurance report of coverage (e.g. Kaiser Family Foundation Source) along with inclusion and prosperity score annually/biannually for impact and trending of interventions (e.g. National Equity Atlas/Policy Link)
 - Inclusion score to review gap between race & ethnicity
 - Prosperity Score-measures outcome for total population
 - Based on 9 indicators centered around: economic vitality (median wages, unemployment, poverty level); readiness (education attainment, disconnected youth, school poverty-free lunch %); and connectedness (air pollution, commute time to work, housing burden)
 - To track metrics and progress, select a screening tool to assess Social Determinants of Health during all community outreach events and patient encounters, such as the following:
 - Accountable Health Communities Health-Related Social Needs Screening Tool <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>
 - Standardized SDoH Screening Questions: https://files.nc.gov/ncdhhs/documents/SDOH-Screening-Tool_Paper_FINAL_20180405.pdf
 - PRAPARE Tool: https://www.nachc.org/wp-content/uploads/2018/05/PRAPARE_One_Pager_Sept_2016.pdf
- Develop a community resource manual that includes a directory of health care providers of color (e.g. Black Pages). A potential resource for this work is the Chapter of the Links, Inc. who developed the Central KY African American Healthcare Directory. They can be reached at either email (frankfortlexingtonlinks@yahoo.com) or website (www.frankfortlexingtonlinksinc.org)
 - To facilitate access to the resource manual the committee suggests housing the manual on the Mayor’s webpage, 211, Health Clinics, Barbershops, Beauty Shops, etc.
- Consider a partnership with the Office and Systems of Medical Licensure as a source to identify African American providers (www.kbml.ky.gov)

Recommended CHIP Work Group- LexBeWell Partnerships

Immediate Actions:

- Each local health system (e.g. St. Joseph's UK healthcare, Baptist) to send an appropriate representative to support the work of CHIP
- Mayor's Office to provide a dedicated liaison: Consider Chris Ford (Commissioner of Social Services; Craig Cammack & Laura Hatfield Director of One Lexington-particularly to oversee the Community Advisory Board and serve as a member of CHIP
- Community Advisory Board elevated and visible on Mayor's website to demonstrate collectivism and collaboration between county government and communities of color
- Statistical Support for development of Common Data Elements and Deriving Data
 - UK Center for Health Equity Transformation (CHET) and College of Public Health to provide statistical support to LFCHD Epidemiologist
 - UK College of Public Health and/or Center for Health Equity Transformation to assign graduate student to support the work of CHIP as part of their degree requirement
 - State Medicaid providers (AETNA; Passport, WellCare, Humana) to provide county-level data on health outcomes to assist with the Minority Health Report Card developed by the KY Department of Public Health.
- Consider a partnership with Sandy K. Brooks or designee the Office and Systems of Medical Licensure as they collect demographic data with licensure (www.kbml.ky.gov)

Immediate Recommended Partnerships

- University of Kentucky's Office of Community Engagement to optimize and strengthen actions to ensure community presence, visibility and impact of efforts
- University of Kentucky's Markey Cancer Center
- UNITE-United in True Racial Equity, the newest research priority area whose mission is to support research & scholarship focused on racial disparities, racial health equity, etc.

Policy Recommendations

- State Medicaid to pursue preventative service State Plan Amendment to reimburse for CHWs.
- Appoint a Lay community member on each county level board to strengthen collaboration between county government and the people of color and to allow input on the neighborhood impact of health equity recommendations.

Immediate Actions:

- Require full time school nurse in every Lexington-Fayette County School
 - To assess for COVID-19 cases and contact tracing;
 - To address the emerging data regarding decreasing vaccination rates due to the pandemic,
 - To assess children for SDoH and connect them to resources
 - To assess for other common screening needs included general health (vision, hearing, oral, emotional/mental health, vaccinations)
- Require sidewalks and green space in every neighborhood
- Require the Commissioners to establish strategic goals based on the Minority Health Report card