Understanding and Addressing Health Disparities

The National Health Service Corps: Empowering Clinicians for Resiliency and Transformative Care

August 2023
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Objectives

After Participating in this Session, Attendees will be Able to:

- Define health disparities and health equity
- Discuss factors that influence health disparities
- Use health disparity information to inform their practice and community engagement efforts

Understanding Health Equity

Health Equity:

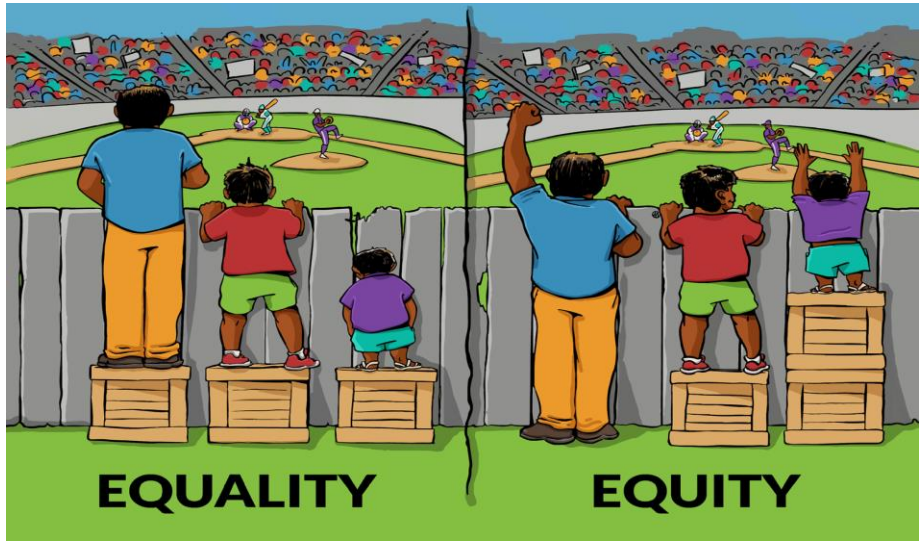
The attainment of the highest level of health for all people.

Health Disparity:

A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.

Source: Office of Disease Prevention and Health Promotion. (n.d.). *Health Equity in Healthy People 2030*.

Equality vs Equity



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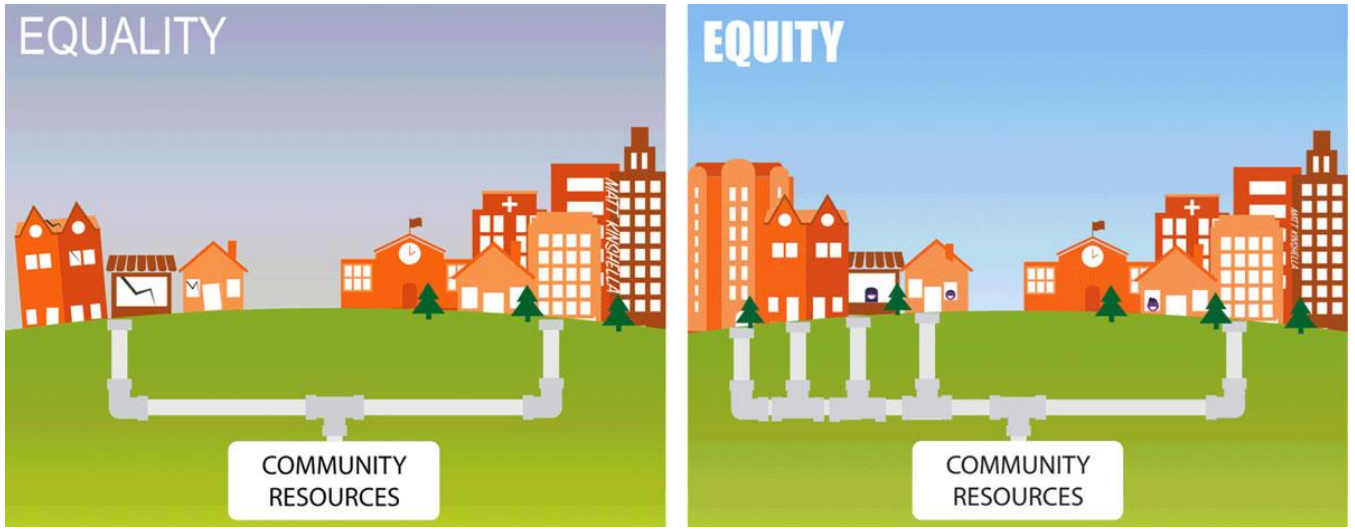

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Social Determinants of Health

"Social Determinants of Health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks"

Source: Office of Disease Prevention and Health Promotion. (n.d.). *Social determinants of health*.

Examples of LGBT+ Disparities

- LGBT youth are 2 to 3 times more likely to attempt suicide.
- LGBT youth are more likely to be homeless.
- Lesbians are less likely to get preventive services for cancer.
- Gay men are at higher risk of HIV and other STDs, especially among communities of color.
- Lesbians and bisexual females are more likely to be overweight or obese.

Source: Office of Disease Prevention and Health Promotion. (n.d.). *Lesbian, gay, bisexual, and transgender health*.

Examples of LGBT+ Disparities (continued)

- Transgender individuals have a high prevalence of HIV/STDs, victimization, mental health issues, and suicide and are less likely to have health insurance than heterosexual or LGB individuals.
- Elderly LGBT individuals face additional barriers to health because of isolation and a lack of social services and culturally competent providers.
- LGBT populations have the highest rates of tobacco, alcohol, and other drug use.

Source: Office of Disease Prevention and Health Promotion. (n.d.). *Lesbian, gay, bisexual, and transgender health*.

Examples of Geographic Disparities

- Nonmetropolitan areas had the largest number of measures showing worse quality care compared with large fringe metropolitan areas.
- Measures where one end of the urban-rural spectrum experienced better quality care were frequently the same measure where the other end of the spectrum experienced worse quality care.

Source: Agency for Healthcare Research and Quality, December 2021

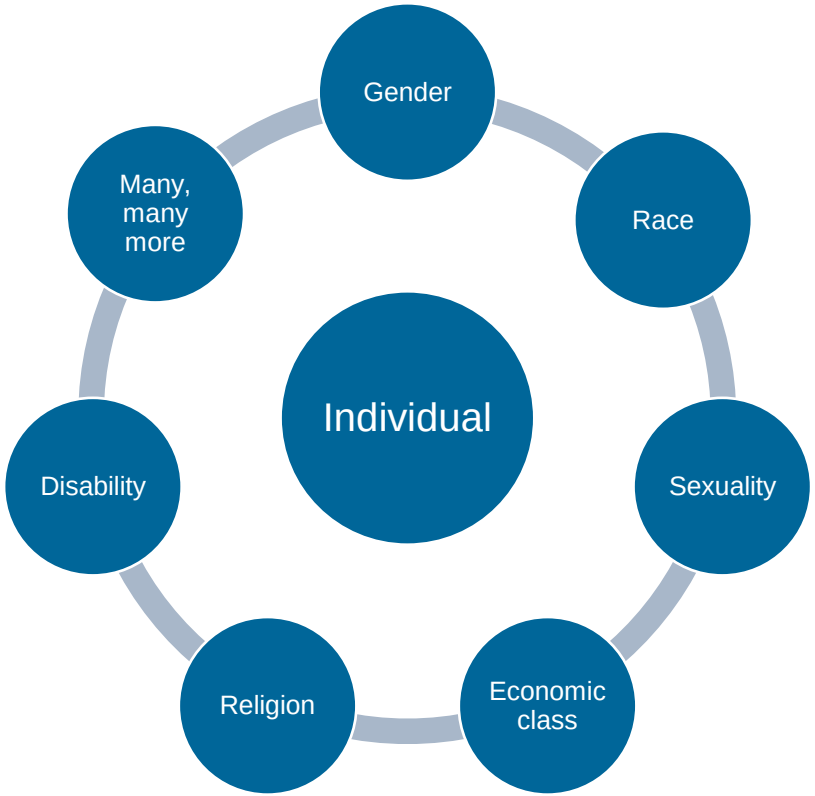
Identifying Health Disparities Among Patient Populations

- When stratified by gender, race, and poverty level, life expectancy in 2012–2016 ranged from 71.0 years among Black men in high-poverty areas to 84.6 years among White women in low poverty areas of the United States.
- Life expectancy decreased as poverty rates increased in all groupings when stratified by race and gender according to US data from 2012-2016.

Source: Office of Health Equity, 2020

Intersecting Circles of Identity

Intersectionality is “the complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, and classism) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups.”



Source: Merriam-Webster, n.d.

Health Equity is Intersectional

- Health outcomes are influenced by many intersecting factors
- Health disparities are driven by inequities beyond the individual's control

Levels of Influence

- Individual
- Interpersonal
- Community
- Societal

Domains of Influence

- Biological (e.g., immunity)
- Behavioral (e.g., coping strategies)
- Physical/built environment
- Sociocultural environment
- Health care system

Source: National Institute on Minority Health and Health Disparities, 2018

Health Disparity Example

- **Non-Hispanic Black/African American Children Have a Higher Median Blood Lead level than Non-Hispanic White Children.**
- **Looking at this Through a Health Equity Lens Allows us to Go Further to Understand the Factors that Contribute to this Disparity.**
  - Is this disparity linked to other social determinants of health?
  - What are the structural or institutional patterns that drive inequities in these factors?
  - How do we address these barriers?

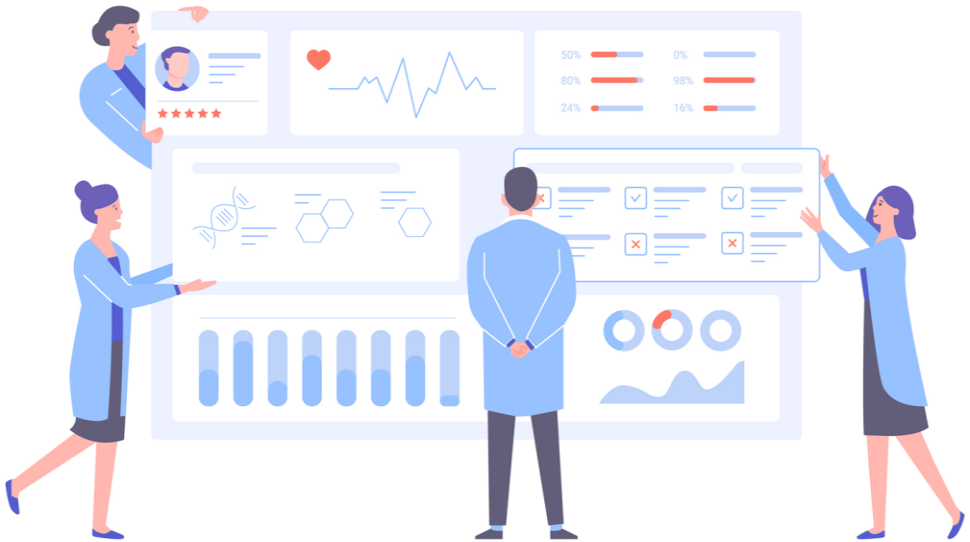
Source: United States Environmental Protection Agency, August 2019

Understanding Local Health Disparities

The Power of Data

Data Provides Clinicians With the Ability to:

- Identify where disparities exist
- Direct efforts and resources to address underlying inequities in care
- Measure progress towards achieving greater equity
- Establish accountability for achieving progress



Data and Your Community

- **Do not assume the inequities in your local community mirror those seen in larger populations.**
- **Examine health outcomes in relation to specific populations, the social, economic, and physical environment, as well as the community's history.**
- **Use the tools best suited to the task to identify health inequities.**
- **Incorporate community members into data collection and interpretation.**

Source: Division of Community Health, 2013

Identifying Health Disparities Among Patient Populations

Data Stratification: The act of sorting data, people, and objects into distinct groups or layers.

Looking at the distribution within each group answers the question: **“What is Happening Within Each Group?”**

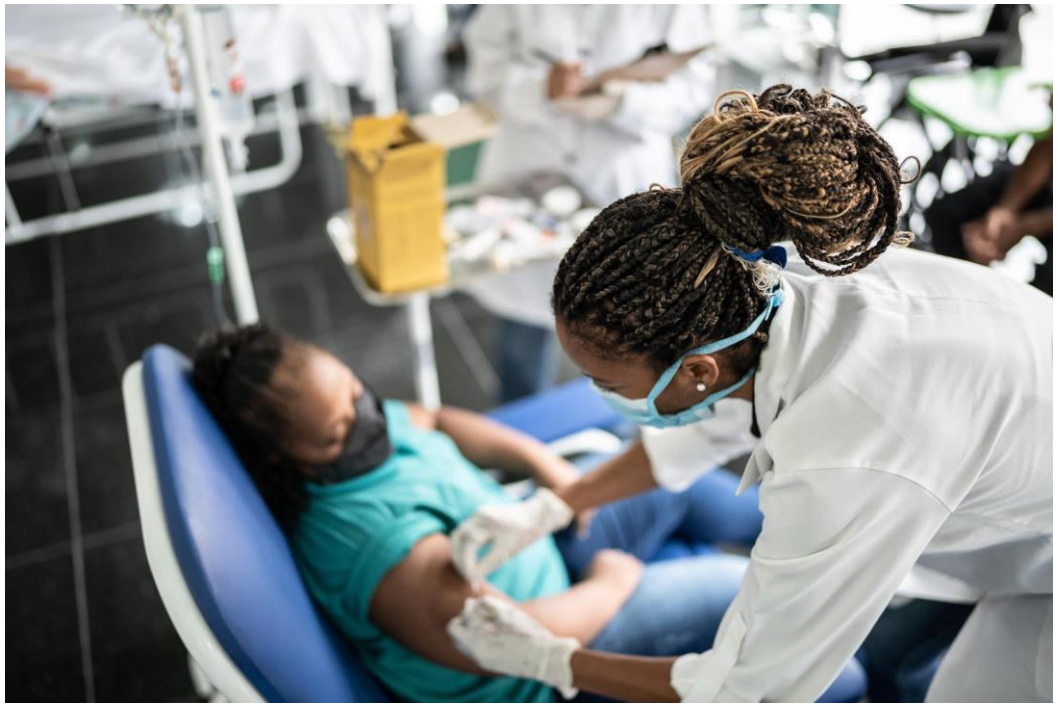
Identifying Health Disparities Among Patient Populations

- A simple positive story often reflects incomplete data stratification that fails to allow health centers to identify where disparities persist.
- Life expectancy at birth has improved substantially during the past 7 decades, increasing from 68.2 years for the total U.S. population in 1950 to 78.6 years in 2017.
- HOWEVER, when stratified by gender, race, and poverty level, life expectancy in 2012-2016 ranged from 71.0 years among Black men in high- poverty areas to 84.6 years among White women in low poverty areas of the United States.

Source: Office of Health Equity, 2020

Using Benchmarks

- A benchmark is a standard or reference against which things may be compared or assessed.
- This benchmark can then be used as a point of comparison to identify disparities within your patient population.



Identifying Benchmarks

Historical Data	Local and National Data
○ Internal to your organization and specific to your patient population such as data pulled from an EHR ○ Allows for the analysis of practices and outcomes at your site over time	○ External to your organization ○ Allows for the comparison of your site's practices and outcomes to others

Understanding Data

-	Process Measure	Outcome Measure
Definition	Indicates what a provider does to improve or maintain health; typically reflects general healthcare recommendations	Reflects the impact of healthcare service or intervention on the health status of patients.
Example 1	Percentage of patients by gender who had a colonoscopy	Mortality rates by gender of individuals with colorectal cancer
Example 2	Percentage of patients by race who were screened for hypertension	Percentage of patients by race with controlled hypertension

Meaningful Measures

Criteria	Key Questions
Prevalence	How prevalent is the disease or condition in your patient population?
Size of Disparity	How large is the gap in quality, access, and/or health outcome between the disparate population and the group with the highest quality for that measure?
Strength of Evidence	How strong is the evidence linking improvement in performance on the measure to improved outcomes in the disparate population?
Ease and Feasibility of Improvement (actionable)	Is the measure actionable (e.g., by providers, clinicians, health plans) among the population with social risk factors?

Example

Health Center Name	Estimated Percentage of Patients with Controlled Blood Pressure
Health Center A	70.91%
Health Center B	61.63%
Healthy People 2020 Benchmark	**60.80%**

*Health Center A and B are located in the same city.

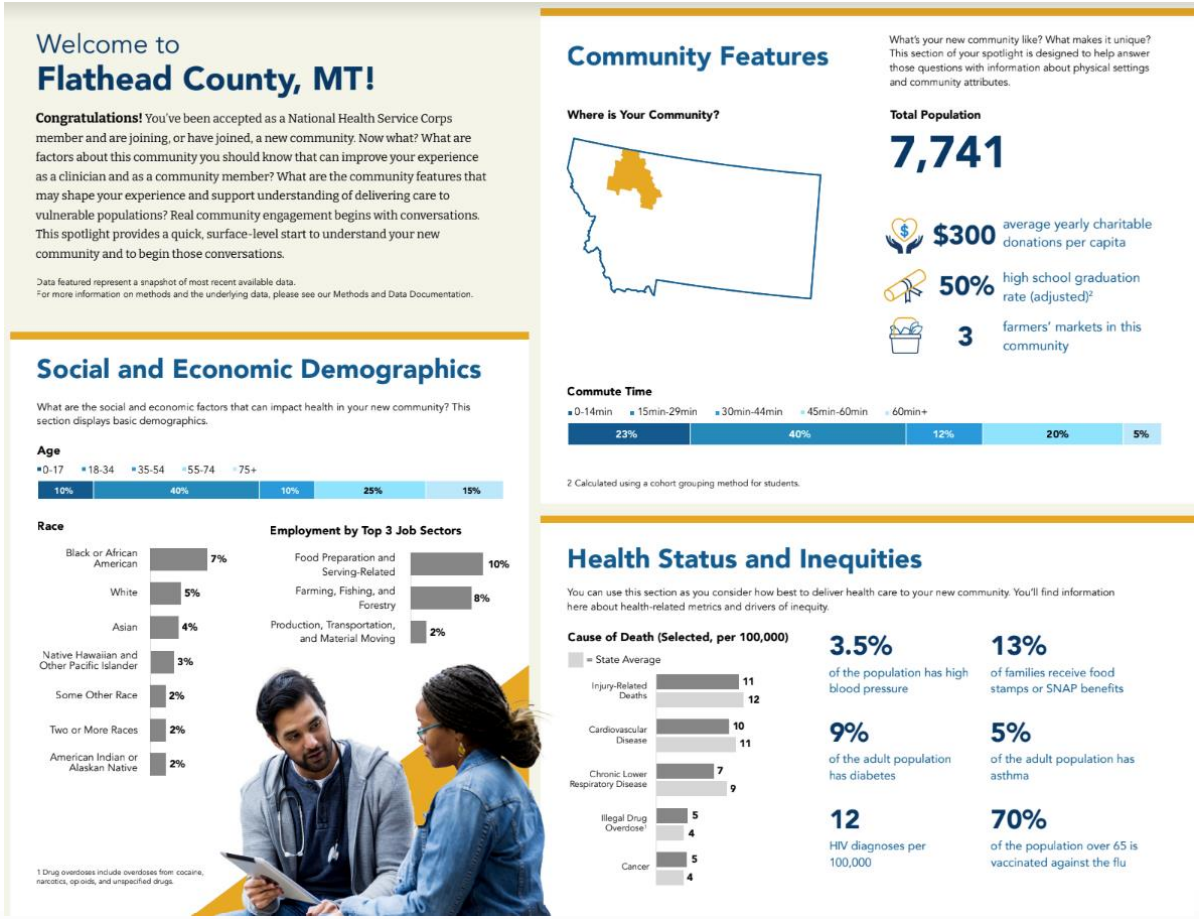
Common Data Sources

- The American Community Survey (ACS), U.S. Census
  - New data annually through a variety of data tables covering social characteristics, economic characteristics, housing characteristics and demographics
- Health Center Program Uniform Data System (UDS)
  - Standardized annual reports including data on patient characteristics, services provided, clinical processes and health outcomes, patient use of services, staffing, costs, and revenues for federally qualified health centers (FQHCs) and FQHC look alikes
- County Health Rankings and Roadmaps
  - Multiple measures pulled from national data sources to help communities understand how health outcomes and health factors will affect the future. The measures include length and quality of life, health behaviors, clinical care, social and economic, and physical environment
- CDC AtlasPlus, Disability and Health Data System
  - Data on HIV, viral hepatitis, sexually transmitted diseases (STDs), tuberculosis, and social determinants of health

Common Data Sources

NHSC Community Spotlights

Customized report including data on local health inequities impacting patient populations at NHSC sites.



Case Study

Central City Concern (CCC) is a Federally Qualified Health Center (FQHC) in Portland, OR. Their work focuses on helping their clients avoid homelessness and provides support in the areas of housing, employment, recovery, and primary health.

CENTRAL CITY CONCERN

HOMES HEALTH JOBS

Case Study

Central City Concern	Local Benchmark
1 out of **33** of individuals in the CCC substance use services have had an overdose	**21.5** overdose hospitalizations per **100,000** in the state of Oregon in 2018; drug or alcohol toxicity contributed to more than **50%** of deaths in unhoused populations in Multnomah county in 2020

Source: Oregon Health Authority, n.d.; Johnson, M. , 2021, December 1

Case Study

Criteria	Key Questions	
Prevalence	How prevalent is the disease or condition in your patient population?	1 out of 33 individuals who engage in substance abuse services at CCC suffers an overdose.
Size of Disparity	How large is the gap in quality, access, and/or health outcome between the disparate population and the group with the highest quality for that measure?	21.5 overdose hospitalizations per 100,000 in the state of Oregon in 2018; drug or alcohol toxicity contributed to more than 50% of deaths in unhoused populations in Multnomah county in 2020
Strength of Evidence	How strong is the evidence linking improvement in performance on the measure to improved outcomes in the disparate population?	"Statistical modeling suggests that high rates of naloxone [generic NARCAN] distribution among laypersons and emergency personnel could avert 21 percent of opioid overdose deaths"
Ease and Feasibility of Improvement (actionable)	Is the measure actionable (e.g., by providers, clinicians, health plans) among the population with social risk factors?	Trainings for staff and residents provided

Source: Johnson, 2020; National Institute on Drug Abuse, 2017

Case Study

Reflection Questions:

- What other data could be a useful tool to identify disparities and inform effective interventions?
- What are some barriers or limitations NHSC sites may face in utilizing data to design interventions specific to their populations?
- Are there additional considerations that organizations should be mindful of when working with data to address health disparities?

Addressing Individual Health Disparities

Work With Your Patient to Develop a Care Plan that Addresses Structural Barriers

Connect your client to support resources to insure they **can** follow the plan

Addressing Health Disparities in Your Practice

- **Identify Opportunities to Bring Awareness of Structural Barriers Using Data**
- **Secure the Support of Organizational Leadership**
- **Identify Health Disparities**
  - Review patient data for health care service and outcomes to identify disparities
  - Facilitate channels for staff and patients to voice concerns

Addressing Health Disparities in Your Practice

Once Disparities and Their Causes Have Been Identified, Consider Ways That Your Organization Can Improve Delivery of Care:

Hiring Practices and Continuing Education

- Do staff at all levels represent diversity of patient population?
- Are staff provided with antiracist, implicit bias, and cultural humility trainings to ensure culturally competent and trauma-informed care is provided?

Accessibility of Health Care Services and Resources

- Are materials available for patients with various communication needs (e.g., Multiple languages, large print, etc.)?
- Are physical spaces navigable for patients with various mobility issues?
- Are appointments accessible to patients with various hours of availability or transportation needs?

Addressing Health Disparities in Your Community

Addressing Both Inequities in Your Broader Community and Inequities in Care Delivery at Your Organization Can Provide Your Patients With the Support They Need to Improve Their Health Outcomes.

You Have a Disparity. Now What?

Community partnerships can support the effective design and implementation of interventions.

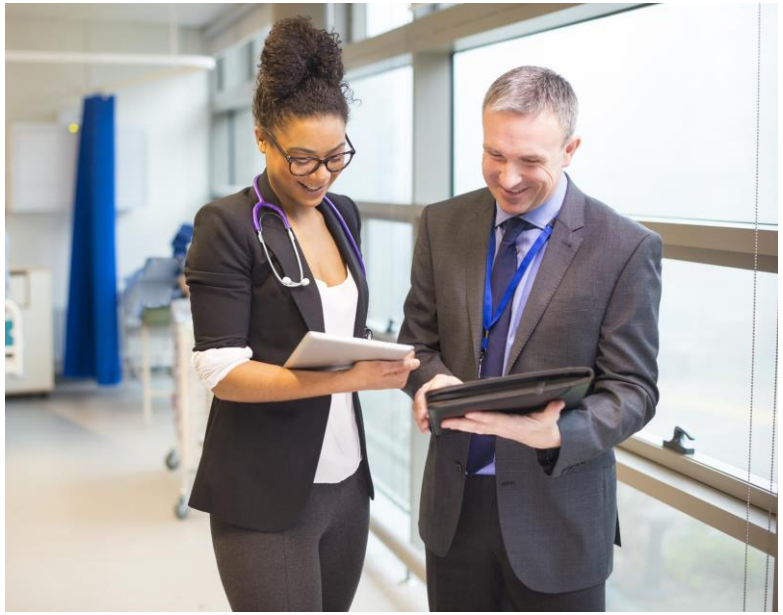
Steps for Fostering Community Partnership

1. Secure Buy-in from Organizational Leadership
2. Identify Potential Partners
3. Engage Potential Partners
4. Establish Partnerships
5. Develop and Implement Programming
6. Track Partnership Outcomes

Fostering Community Partnerships

Secure Buy-In From Your Organization's Leadership

- Discuss opportunities to address a health disparity and its causes through community partnership
- Discuss opportunities to carve out time in your schedule to focus on partnership activities



Fostering Community Partnerships

Identify Potential Partners

- Who is most impacted by a specific issue?
- What systemic factors are contributing to the disparity?
- Which agencies/stakeholders work within the systems that are contributing the disparity?
- Who is currently or may in the future provide the needed services, skills or knowledge to accomplish the goals of the partnership?

Fostering Community Partnerships

Identify Potential Partners

Community-Based Stakeholders Interested in Partnerships to Address Local Health Disparities and Inequities Include:

- Members of neighborhood and city councils
- Faith leaders
- Representatives from hospital organizations
- Public health departments
- Community-based organizations
- Business leaders
- Local advocates
- Schools

Fostering Community Partnerships

Engage Potential Partners

- Schedule an introductory meeting with potential partners/stakeholders.

- Prepare notes on the important talking points prior to the meeting: **What is the Issue of Concern, Why It's Important to You or Your Agency, and What Kind of Collaboration is Being Sought**.

- If you establish that shared priorities exist and both parties are interested in collaborating, schedule a more formal meeting to explore next steps.

Fostering Community Partnerships

Establish Partnerships

If a Formal Partnership is Established, Consider the Following:

- Creating a charter describing the purpose and goals of the group
- Offering compensation to patients or community members for their participation
- Guidance on how decisions will be made
- Clarifying key roles and responsibilities
- Scheduling regular meetings for action items, updates, and monitoring progress

Fostering Community Partnerships

Develop and Implement Programming

- Identify Health Needs With Data Analysis and With the Participation or Input From Key Local Partners.
- Develop Interventions Based on Prioritized Community Health Needs.
  - Agree upon process and outcome metrics
  - Ensure partners agree on the scope of the interventions
  - Identify community assets to determine all available resources and potential partners

Fostering Community Partnerships

Develop and Implement Programming

Identify and Apply for Funding if Needed

- Planning grant
- Start–up grant
- Program grant
- Research grant
- Determine how new initiatives will be sustained when grant funds run out

Fostering Community Partnerships

Track Partnership Outcomes

- Adopt a partnership assessment survey tool to regularly gauge partnership satisfaction.
- Measure the impact of the partnership's efforts on the stated goals.
- Share data among partners and with community stakeholders and community members.
- Evaluate how the partnership facilitates ongoing community relationships
- Celebrate successes and communicate stories broadly.

Additional Resources

Health Resources and Services Administration, Bureau of Health Workforce

The National Health Service Corps: Empowering Clinicians for Resiliency and Transformative Care Community Assessment Guide

Advancing Health Equity

Using Data to Reduce Disparities and Improve Quality

Questions/Comments?

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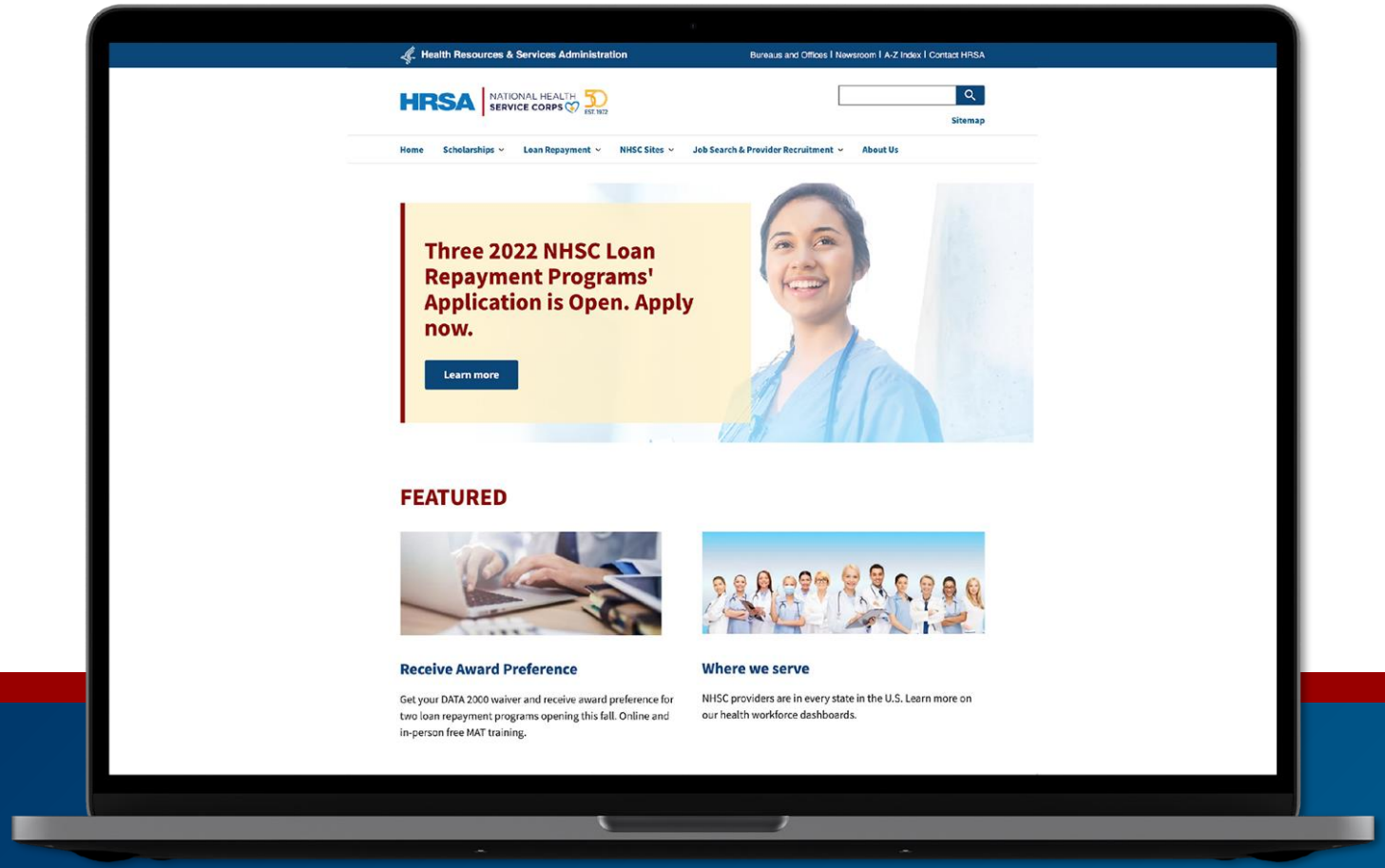
Additional Resources Available:



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