HRSA NATIONAL HEALTH SERVICE CORPS

Understanding and Addressing Health Disparities

The National Health Service Corps Empowerment Initiative: Advancing Clinician Wellness & Health Equity

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What is your role related to the NHSC?

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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."

Healthy People 2030

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

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EQUALITY:
Everyone gets the same – regardless if it's needed or right for them.

EQUITY:
Everyone gets what they need – understanding the barriers, circumstances, and conditions.

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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*.

Structural & Social Drivers of Health Inequities

Structural Inequities

- Racism in housing access, e.g.redlining (discriminatory lending) leading to residential segregation

Social Determinants of Health

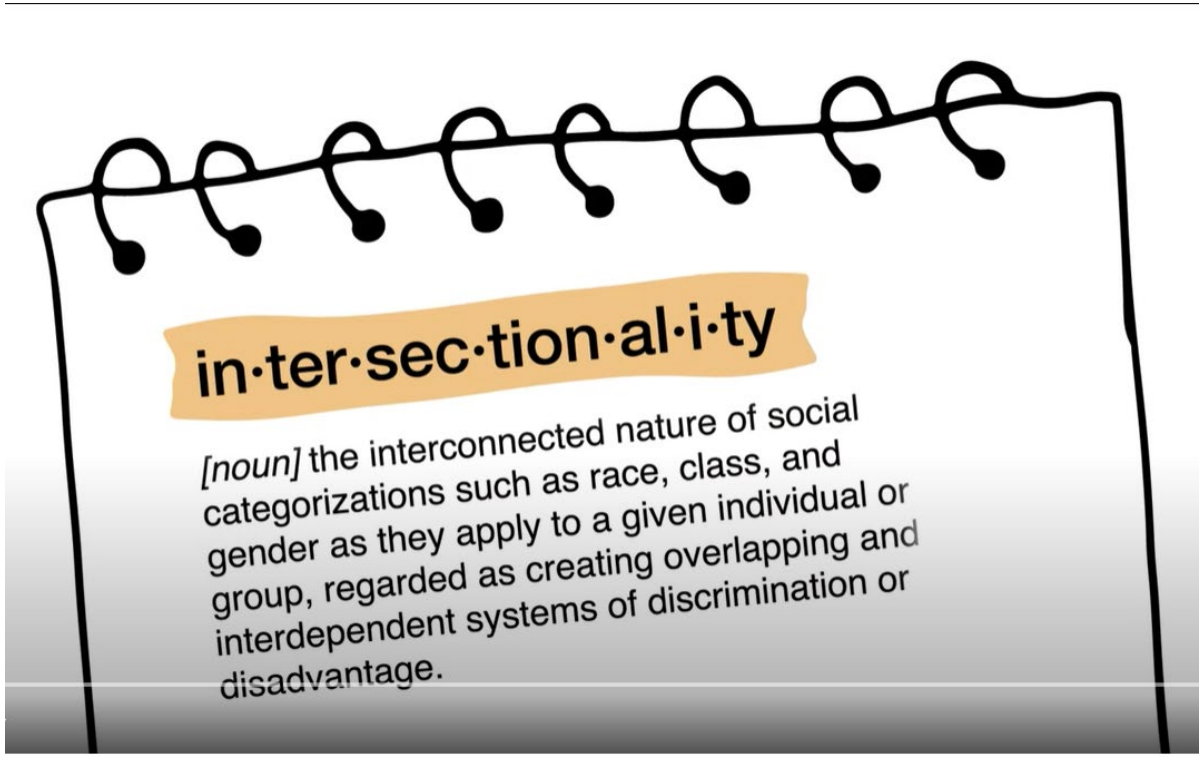
- People of color more likely to live in substandard housing in areas with high levels of environmental pollutants

Health Inequities

- People of color more likely to have higher rates of health issues related to environmental pollutants, e.g. asthma, cancer, and other chronic diseases

Source: Lee et al., 2022; National Academies of Sciences, Engineering, and Medicine, 2017

Intersectionality and Health



Video Link: https://www.youtube.com/watch?v=LFx3zDQQ3Vw&list=PLvrp9iOILTQbC71TLvaECQHQG4HuQPJmi&index=7

Source: Center for Disease Control and Prevention, 2023

Health Equity is Intersectional

		Levels of Influence*			
		Individual	**Interpersonal**	**Community**	**Societal**
Domains of Influence *(Over the Lifecourse)*	**Biological**	Biological Vulnerability and Mechanisms	Caregiver–Child Interaction Family Microbiome	Community Illness Exposure Herd Immunity	Sanitation Immunization Pathogen Exposure
	Behavioral	Health Behaviors Coping Strategies	Family Functioning School/Work Functioning	Community Functioning	Policies and Laws
	Physical/ Built Environment	Personal Environment	Household Environment School/Work Environment	Community Environment Community Resources	Societal Structure
	Sociocultural Environment	Sociodemographics Limited English Cultural Identity Response to Discrimination	Social Networks Family/Peer Norms Interpersonal Discrimination	Community Norms Local Structural Discrimination	Social Norms Societal Structural Discrimination
	Health Care System	Insurance Coverage Health Literacy Treatment Preferences	Patient–Clinician Relationship Medical Decision-Making	Availability of Services Safety Net Services	Quality of Care Health Care Policies
Health Outcomes		**Individual Health**	**Family/ Organizational Health**	**Community Health**	**Population Health**

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.

Source: United States Environmental Protection Agency, March 2020

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What social determinants of health could be related to this disparity in blood lead levels ?

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What are the structural and institutional inequities that drive these social determinants?

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How do we address these structural inequities?

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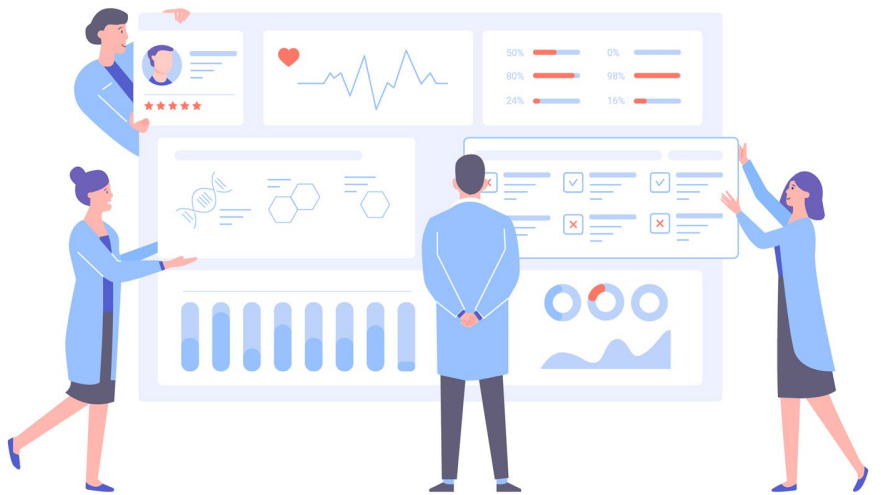
Understanding Local Health Disparities

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?”**

Source: American Society for Quality, n.d.; DeMeester et al., 2020

Data Stratification Example

- 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

Source: DeMeester et al., 2020

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

Source: DeMeester et al., 2020

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?

Source: DeMeester et al., 2020

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.

Source: Health Resources and Services Administration, 2022

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
- National Center for HIV, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Atlas Plus
  - Data on HIV, viral hepatitis, sexually transmitted diseases (STDs), tuberculosis, and social determinants of health

Additional Resource

Using Data to Reduce Disparities and Improve Quality

Advancing Health Equity, 2021

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.

Case Study

Central City Concern	Local Benchmark
1 out of **33** of individuals receiving CCC substance use services have had an overdose	**3.7** deaths per **100,000** were attributed to overdoses in Multnomah County in 2019; 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, 2021

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?	• 3.7 deaths per 100,000 were attributed to overdoses in Multnomah County in 2019 • 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" • 80% of reported overdose incidents occurred in or just outside CCC housing buildings
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, NARCAN was made available and

Source: Johnson, 2020; National Institute on Drug Abuse, 2017; DePietro et al., 2023

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?

Additional Resources

A Toolkit to Advance Racial Health Equity in Primary Care Improvement

(California Improvement Network, 2022)

Racial and Health Equity: Concrete STEPS for Health Systems

(American Medical Association & Health Begins, 2022)

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.

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

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

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?

Identify Potential Partners (continued)

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

Engage Potential Partners

1. Schedule an introductory meeting with potential partners/stakeholders.
2. 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**.
3. If you establish that shared priorities exist and both parties are interested in collaborating, schedule a more formal meeting to explore next steps.

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

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

Develop and Implement Programming (continued)

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

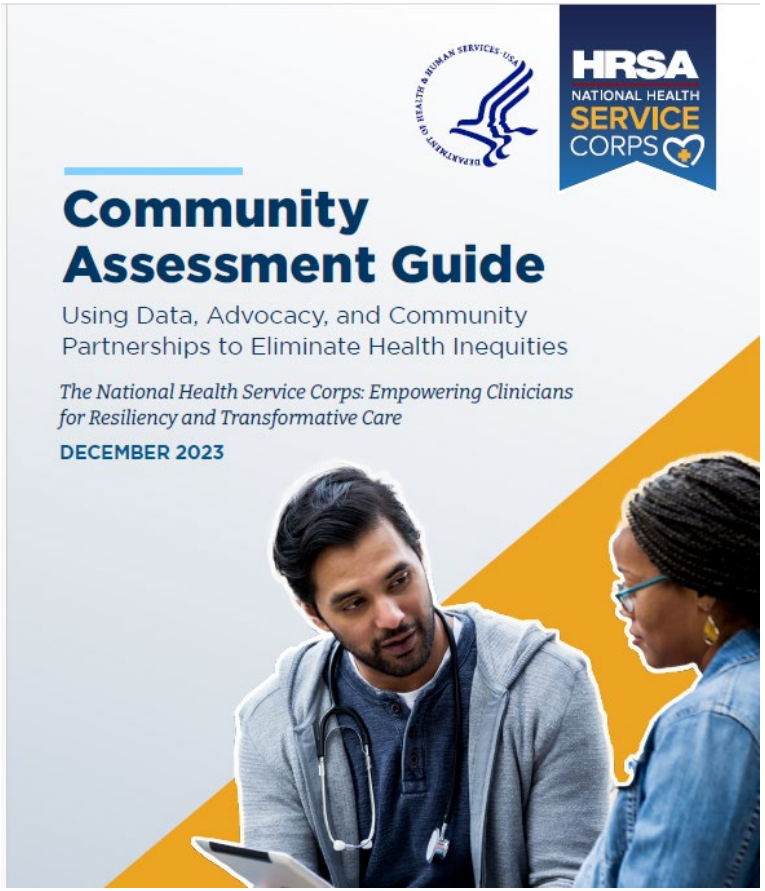
Track Partnership Outcomes

- ✓ 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

Community Assessment Guide: Using Data, Advocacy, and Community Partnerships to Eliminate Health Inequities

(Health Resources and Services Administration
Bureau of Health Workforce, 2023)



Questions/Comments?

Acknowledgements

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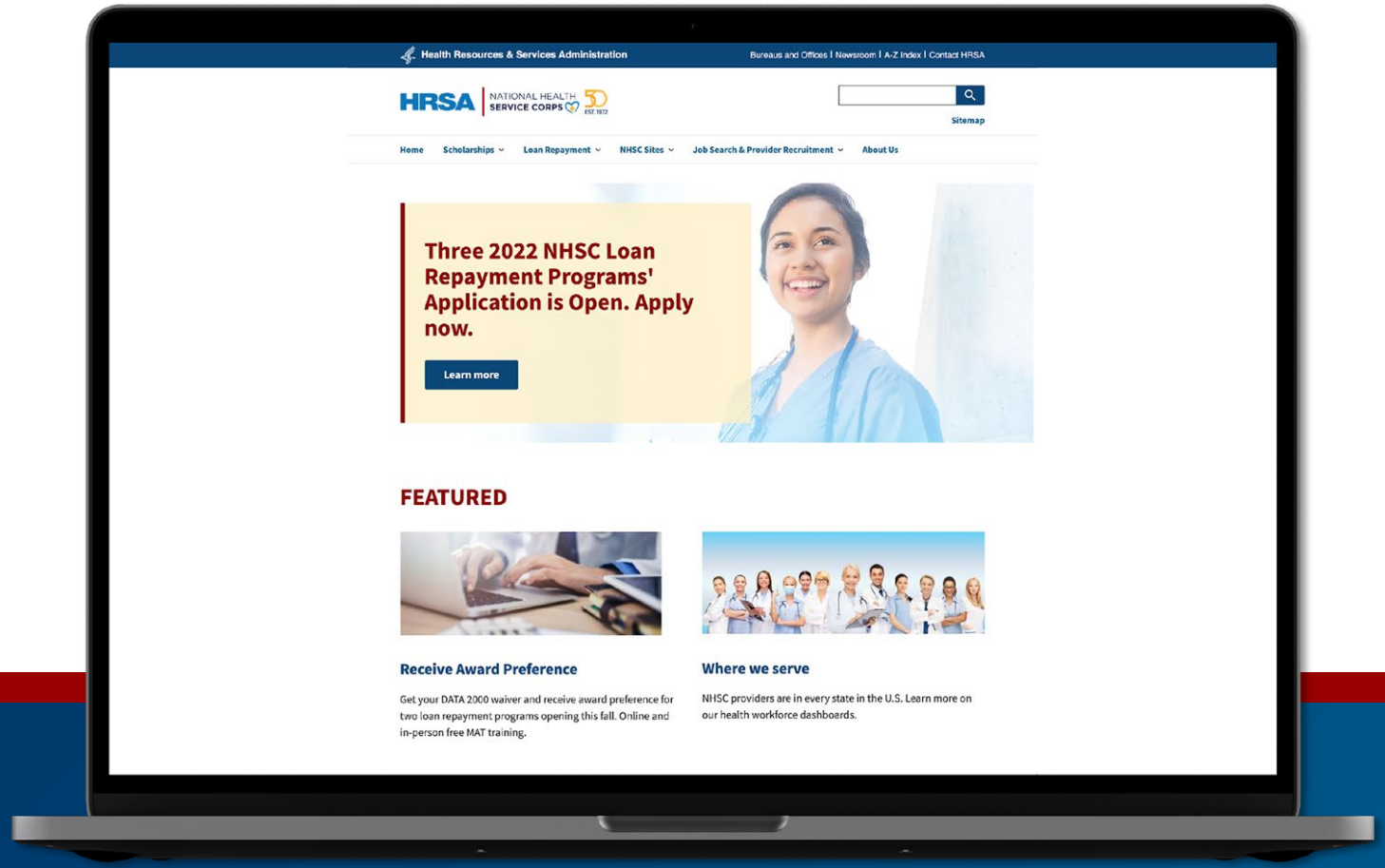
Additional Resources Available:



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