GETTING TO THE ROOT OF THINGS:
USING A DATA INFORMED HEALTH EQUITY APPROACH TO IDENTIFY AND REDUCE HEALTH DISPARITIES

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Learning Objectives

• At the conclusion of this presentation, participants will be able to:
  
• Define health equity and distinguish it from health disparities and health equality.
• Identify 5 social determinants of health and their impact on health
• Identify at least 3 drivers of health disparities in Tennessee
• List at least 3 ways that social determinants of health impact the clinical decision-making process.
OVERVIEW
What is integrated care?

The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Integrated Care **Must** Fulfill the Functions of Primary Care

The 10 Cs of Primary Care

1. Continuous  
2. Comprehensive  
3. Coordinated  
4. Contact—first  
5. Competence  
6. Cost-effective  
7. Communication  
8. Collaboration  
9. Compliance  
10. Competing demands

How can we use the functions of primary care to reduce health disparities and promote health equity?
Nonmedical factors such as employment, income, housing, transportation, childcare, education, discrimination, and the quality of the places where people live, work, learn, and play, which influence health.

Ensuring that everyone has equal access to certain resources (e.g., health services).

Everyone has a “fair and just opportunity to be as healthy as possible.” Involves removing and eliminating obstacles to health (e.g., poverty, discrimination, powerlessness, lack of good jobs with fair pay, quality education/housing, safe environments, health) that lead to health disparities. Both a process and a goal.

Let’s start with definitions

Disparities

Equity

Equality

Social Determinants

Differences in health outcomes. Often barriers embedded in health care systems. Differences in access to and use of care, quality of care, insurance coverage. Driven in large part by systems (e.g., racism, stigma, prejudice, discrimination, historical traumas).

Nonmedical factors such as employment, income, housing, transportation, childcare, education, discrimination, and the quality of the places where people live, work, learn, and play, which influence health.

https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html
## Social Determinants of Health

<table>
<thead>
<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social Integration</td>
</tr>
<tr>
<td>Income</td>
<td>Transportation</td>
<td>Language</td>
<td>Access to Healthy Options</td>
<td>Support Systems</td>
</tr>
<tr>
<td>Expenses</td>
<td>Safety</td>
<td>Early Childhood Education</td>
<td></td>
<td>Community Engagement</td>
</tr>
<tr>
<td>Debt</td>
<td>Parks</td>
<td>Vocational Training</td>
<td></td>
<td>Discrimination</td>
</tr>
<tr>
<td>Medical Bills</td>
<td>Playgrounds</td>
<td>Higher Education</td>
<td></td>
<td>Stress</td>
</tr>
<tr>
<td>Support</td>
<td>Walkability</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Zip Code/Geography</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Health Outcomes
- Mortality
- Morbidity
- Life Expectancy
- Health Care Expenditures
- Health Status
- Functional Limitations

### Health Care System
- Health Coverage
- Provider Availability
- Provide
- Linguistic and Cultural Competency
- Quality of Care
How do social determinants of health negatively impact health outcomes?

- Lower life expectancy
- Maternal and fetal mortality
- Morbidity (i.e., chronic health conditions—stroke, hypertension, diabetes, liver disease)
- Strain on mental health
- Lower standards of care
- Lower referral rates
- Sleep disturbances
- Misdiagnosis
- Undertreatment
- Death
REALITY: One gets **more than** is needed, while the other gets **less than** is needed. Thus, a huge disparity is created.

EQUALITY: The assumption is that everyone benefits from the same supports. This is considered to be equal treatment.

EQUITY: Everyone gets the support they need, which produces equity.

JUSTICE: All 3 can see the game without supports or accommodations because the cause(s) of the inequity was addressed. The systemic barrier has been removed.
Root Causes

The leaves are the result of the things supplied to the tree via the roots. The drivers of disparities.

What roots have you supplied?
THE DRIVERS OF HEALTH IN TENNESSEE

THE DRIVERS OF HEALTH

- 30% Health Behavior
- 40% Social & Economic Environment
- 20% Clinical Care
- 10% Physical Environment

HEALTH BEHAVIORS

- 22% Adult Smokers (2016) in TN
- 82% Did Not Meet Exercise Guidelines (2015) in TN

SOCIAL & ECONOMIC

- 74% Less Than A Bachelor's Degree (2016) in TN
- 69% Poverty (2016) in TN

CLINICAL CARE

- 9.0% Uninsured (2016) in TN
- 22% Adults w/ No Primary Care Provider (2016) in TN

PHYSICAL ENVIRONMENT

- 16% Adults w/ Housing Issues (2013) in TN
- 31% No Access to Exercise Opportunities (2014) in TN

SycamoreInstituteTN.org

Health disparities in Tennessee
Fall 2020
Analysis of health disparities in Tennessee

• The social and economic environment contributes more to disparities in health than any other factors

• These determinants are rooted in historical systems, laws, and mandates that limited access to healthcare and resources for some groups

• Historically, public health crises have had a disproportionate impact on Black and Brown Americans

Young, 2020—TN Justice Center
Figure 2

People of Color Fare Worse than their White Counterparts Across Many Measures of Health Status

Number of health status measures for which group fared better, the same, or worse compared to White counterparts:

- Black: 19 (5 Better, 17 No Difference, 3 Worse)
- American Indian or Alaska Native: 17 (7 Better, 2 No Difference, 10 Worse)
- Hispanic: 14 (11 Better, 2 No Difference, 3 Worse)
- Native Hawaiian or Other Pacific Islander: 8 (3 Better, 6 No Difference, 3 Worse)
- Asian: 21 (3 Better, 3 No Difference, 15 Worse)

Note: Measures are for 2018 or the most recent year for which data are available. "Better" or "Worse" indicates a statistically significant difference from Whites at the p<0.05 level. No difference indicates no statistically significant difference. "Data limitation" indicates data are no separate data for a racial/ethnic group, insufficient data for a reliable estimate, or comparisons not possible due to overlapping samples. Persons of Hispanic origin may be of any race but are categorized as Hispanic for this analysis; other groups are non-Hispanic.
Health disparities and COVID-19

• Health disparities have been exacerbated during the COVID-19 pandemic
  • Black and Latinx residents of the US are 3x more likely to become infected and 2x more likely to die from COVID-19 than White Americans
  • These numbers are likely underestimated because at least 1.5 million case records do not include information about race, ethnicity, and county of resident for positive cases

• In Tennessee:
  • Black Tennesseans constitute 17% of the state population; yet they account for 20% of COVID cases and 36% of deaths
  • Latinx Tennesseans constitute 5% of the state population; 35% of COVID cases and 10% of deaths
  • 24% of total cases in TN are marked “pending” for race/ethnicity

Despres, 2020- Salud America!; Young, 2020- TN Justice Center
People of color have had higher rates of infection, hospitalization, and death due to COVID-19.

Risk of infection, hospitalization, and death compared to White people in the U.S., adjusted for age:

- American Indian or Alaska Native
- Black
- Hispanic
- Asian
- White

Health Disparities and CHS
Fall 2020
Integrated care and health equity

- CHS’ Integrated care model
  - Greater opportunities to address SDOH at all levels of care
  - Meet needs as they arise; being proactive vs reactive
  - Patient Centered Medical Home (PCMH)

- Health care and health disparities are still prevalent in the populations that we serve
  - Consider intersectionality and SDOH
  - Barriers to care (e.g., financial, social, cultural), adherence challenges, access to affordable housing, food, and transportation
## Hypertension in 2019

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Hypertension</th>
<th>HTN Controlled</th>
<th>Percentages of HTN Controlled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latino</td>
<td>779</td>
<td>526</td>
<td>67.5%</td>
</tr>
<tr>
<td>Asian</td>
<td>57</td>
<td>37</td>
<td>64.9%</td>
</tr>
<tr>
<td>Native Hawaiian</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Other Pacific Islander</td>
<td>46</td>
<td>25</td>
<td>54.3%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>2812</td>
<td>1579</td>
<td>56.15%</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>47</td>
<td>33</td>
<td>70.2%</td>
</tr>
<tr>
<td>White</td>
<td>11027</td>
<td>7317</td>
<td>66.3%</td>
</tr>
<tr>
<td>More than once race</td>
<td>72</td>
<td>50</td>
<td>69.4%</td>
</tr>
<tr>
<td>Ethnicity not disclosed</td>
<td>390</td>
<td>243</td>
<td>62.3%</td>
</tr>
</tbody>
</table>
## Hypertension in 2019, continued

<table>
<thead>
<tr>
<th>Group</th>
<th>Total Cases</th>
<th>HTN Cases</th>
<th>Percentage of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who are migrants</td>
<td>247</td>
<td>168</td>
<td>68.02%</td>
</tr>
<tr>
<td>Patients living in public housing</td>
<td>3676</td>
<td>2298</td>
<td>62.51%</td>
</tr>
<tr>
<td>Patients experiencing homelessness</td>
<td>1880</td>
<td>1801</td>
<td>59.97%</td>
</tr>
<tr>
<td>Patient Total</td>
<td>15541</td>
<td>10005</td>
<td>64.38%</td>
</tr>
</tbody>
</table>
Patients with Hypertension by Hispanic and Controlled Status
Year Ending 2020

- Unreported/Refused to Report
- More than One Race
- American Indian/Alaskan Native
- Other Pacific Islander
- Native Hawaiian
- Asian
- Hispanic/Latino
- Black/African American
- White

Legend:
- Hispanic (Diagnosed)
- Non-Hispanic (Diagnosed)
- Hispanic (Controlled)
- Non-Hispanic (Controlled)
<table>
<thead>
<tr>
<th>Group</th>
<th>Total Cases</th>
<th>Diabetes Cases</th>
<th>Percentage of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who are migrants</td>
<td>202</td>
<td>120</td>
<td>59.41%</td>
</tr>
<tr>
<td>Patients living in public housing</td>
<td>1515</td>
<td>1034</td>
<td>68.25%</td>
</tr>
<tr>
<td>Patients experiencing homelessness</td>
<td>725</td>
<td>472</td>
<td>65.1%</td>
</tr>
<tr>
<td>Patient Total</td>
<td>6764</td>
<td>4537</td>
<td>67.08%</td>
</tr>
</tbody>
</table>
Patients with Diabetes by Hispanic and Uncontrolled Status
Year Ending 2020

Unreported/Refused to Report
More than One Race
Other Pacific Islander
American Indian/Alaskan Native
Native Hawaiian
Hispanic
Asian
Black
White

- Non-Hispanic (HbA1C >9% or No Test)
- Hispanic (HbA1C >9% or No Test)
- Non-Hispanic (Diagnosed)
- Hispanic (Diagnosed)
Strategies to address racism and health

• Health disparities cannot be addressed without addressing racism, prejudice, and discrimination in healthcare

• Using a socio-ecological model, SDOH can be addressed at every level
  • Interventions should address providers, the systems in which they work, and the society in which they exist
  • Understanding clinical factors through a social justice lens
  • Goal is to create health equity - focused on outcomes
  • Meaningful change will occur through daily decisions - not through diversity trainings alone
Lessons learned

• What can you do differently to address health disparities in your daily practice?
• What would be a good way to promote health equity in your clinic(s)?
• How do SDOH inform your clinical decision-making process?
  • What are the benefits/drawbacks of using a social justice lens when making diagnostic decisions?
  • How could this impact your treatment planning/goals?
• Thoughts on promoting health equity with the rest of your integrated care team?
"Integrated care stands to benefit individuals from diverse medically underserved groups who are vulnerable to adverse health outcomes at the intersection of the physical, psychological, social, and cultural aspects of health...It can enhance health provider ability to develop integrative diagnoses of physical, behavioral, sociocultural, and systemic aspects of health and illness; assess for psychological disorders; address modifiable health behavior practices; offer timely initiation of mental health treatment; and promote patient empowerment, adherence and retention in care. Integrated care can increase focus on the intersection of health care delivery practices with contextual social and cultural dimensions that influence patient experiences of health and illness, patient health behavior practices, and patient-health provider communication and relationships" (Farber et al., 2017, p. 31-32)
RESOURCES

- Health Equity and Prevention Primer
  - https://www.preventioninstitute.org/tools/tools-general/health-equity-toolkit
- AHRQ National Healthcare & Disparities Report
  - https://www.samhsa.gov/behavioral-health-equity
- National Network to Eliminate Disparities in BH
  - www.NNED.net
- National Culturally & Linguistic Appropriate Services (CLAS) Standards
  - https://www.thinkculturalhealth.hhs.gov/clas
- SAMSHA Behavioral Health Equity
  - https://www.samhsa.gov/behavioral-health-equity
- The Health Equity Initiative
  - http://www.healthequityinitiative.org/hei/
- Human Impact Partners
  - https://humanimpact.org/
- Office of Minority Health
  - https://minorityhealth.hhs.gov/
- The National LGBT Health Education Center
  - https://www.lgbthealtheducation.org/
- National Immigration Law Center
  - https://www.nilc.org/
- Public Health Learning Network
  - https://nnphi.org/phln/
QUESTIONS?

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