2021 Behavioral Health and Primary Care Integration Conference

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

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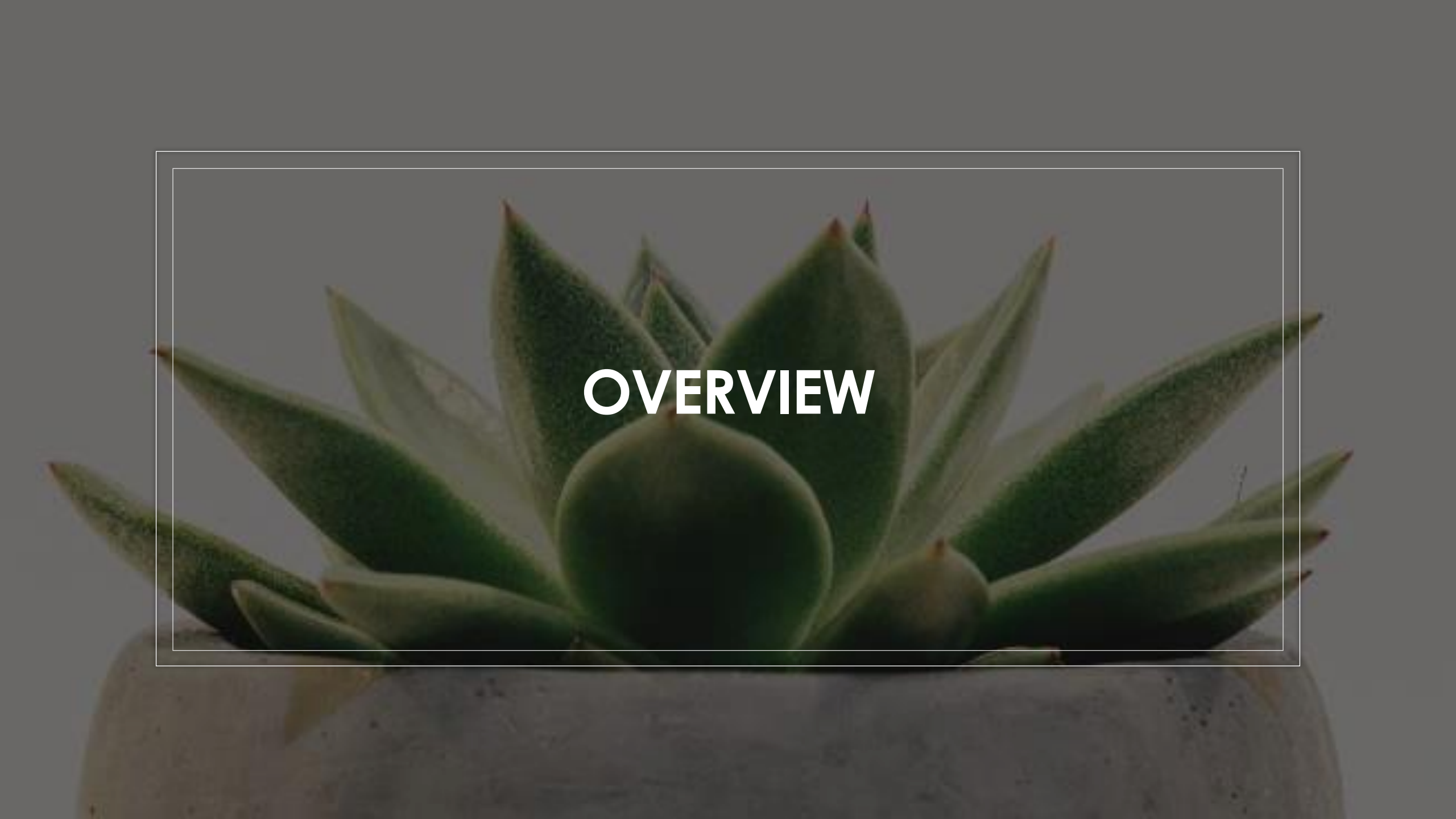
Learning Objectives

- 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.

AHRQ, 2013. www.integrationacademy.ahrq. https://integrationacademy.ahrq.gov/sites/default/files/2020-06/Lexicon.pdf

Integrated Care Must Fulfill the Functions of Primary Care

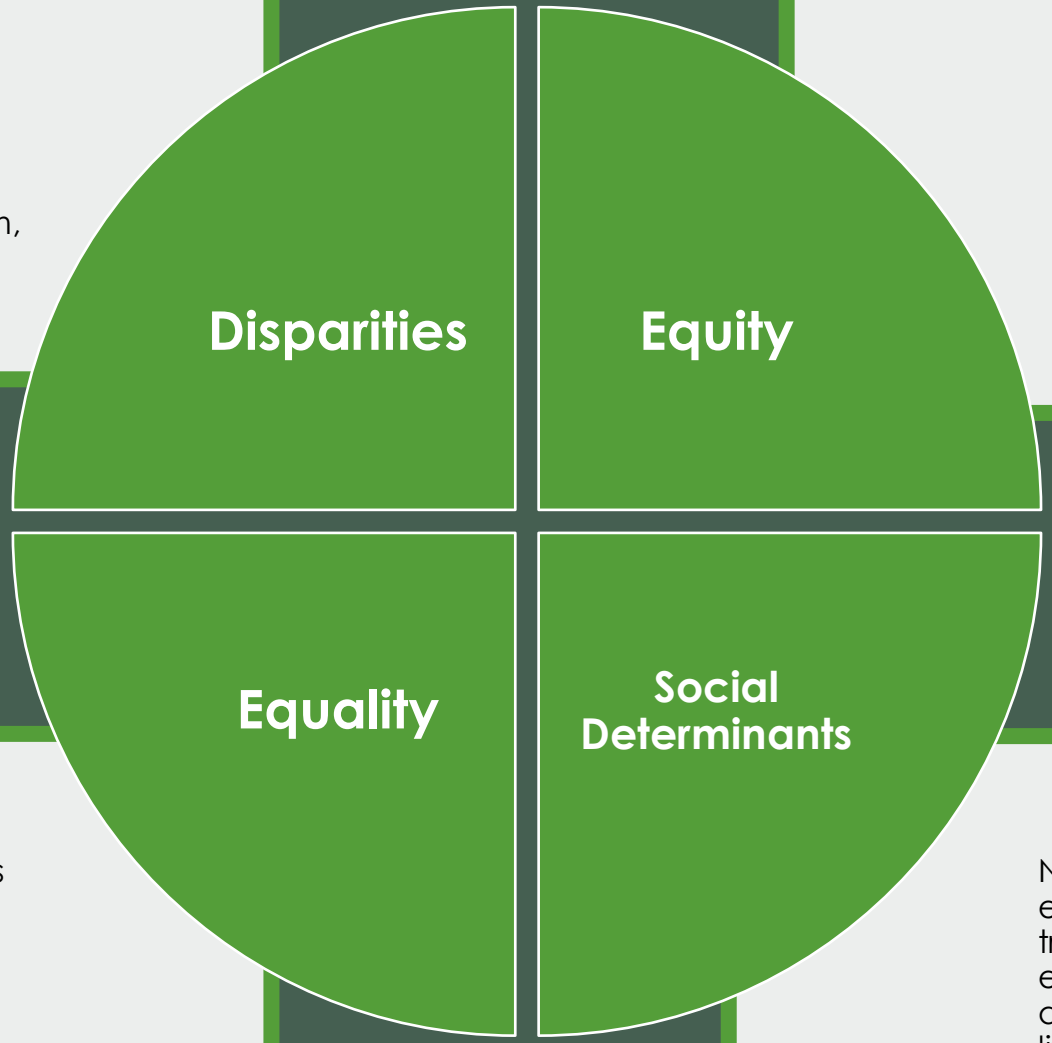
The 10 Cs of Primary Care

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

Kroenke, 2004. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC14923

How can we use the functions of primary care to reduce health disparities and promote health equity?

Let's start with definitions



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)

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

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

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

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social Integration	Health Coverage
Income	Transportation	Language	Access to Healthy Options	Support Systems	Provider Availability
Expenses	Safety	Early Childhood Education		Community Engagement	Provide Linguistic and Cultural Competency
Debt	Parks	Vocational Training		Discrimination	
Medical Bills	Playgrounds	Higher Education		Stress	Quality of Care
Support	Walkability				
	Zip Code/ Geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

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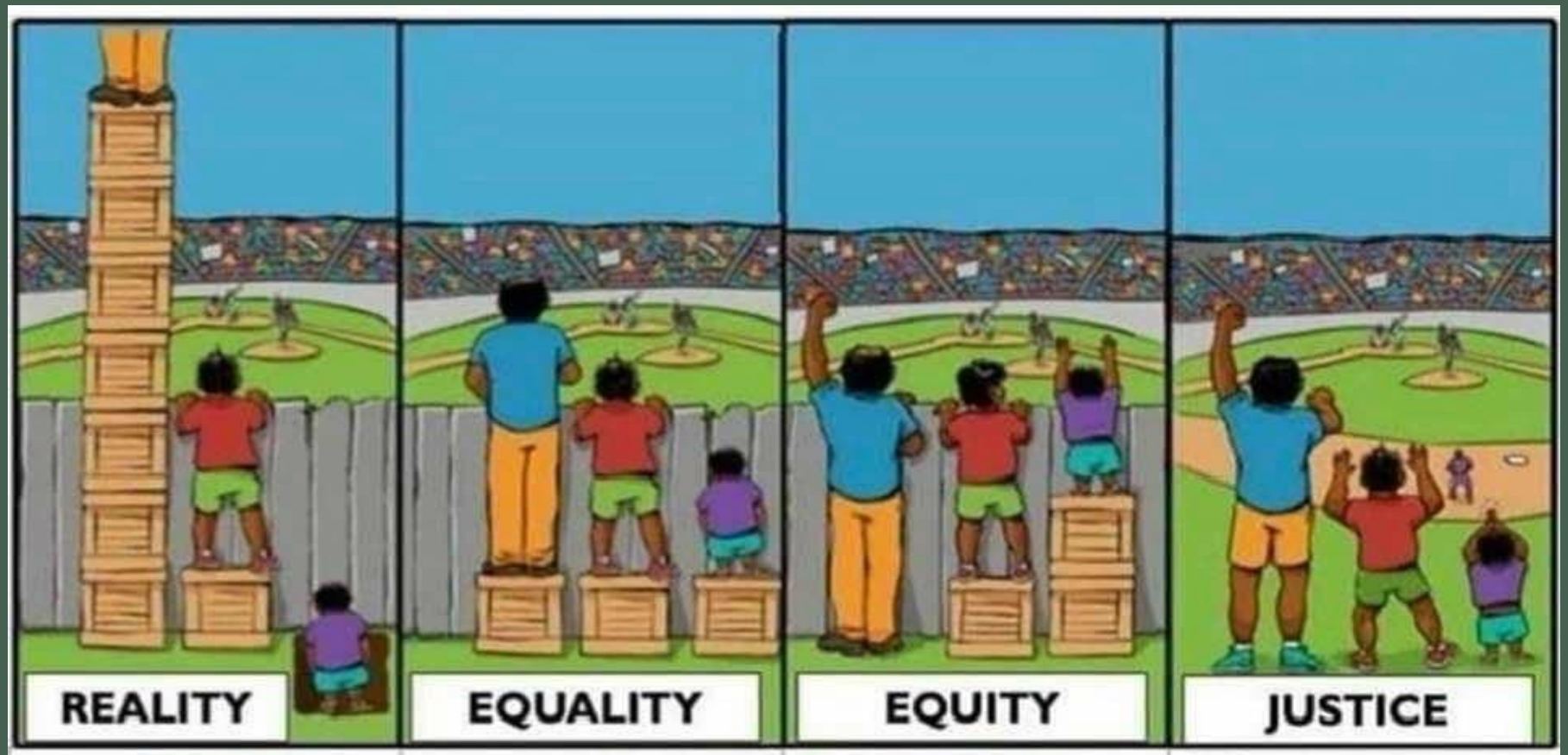
How do social determinants of health negatively impact health outcomes?

- 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

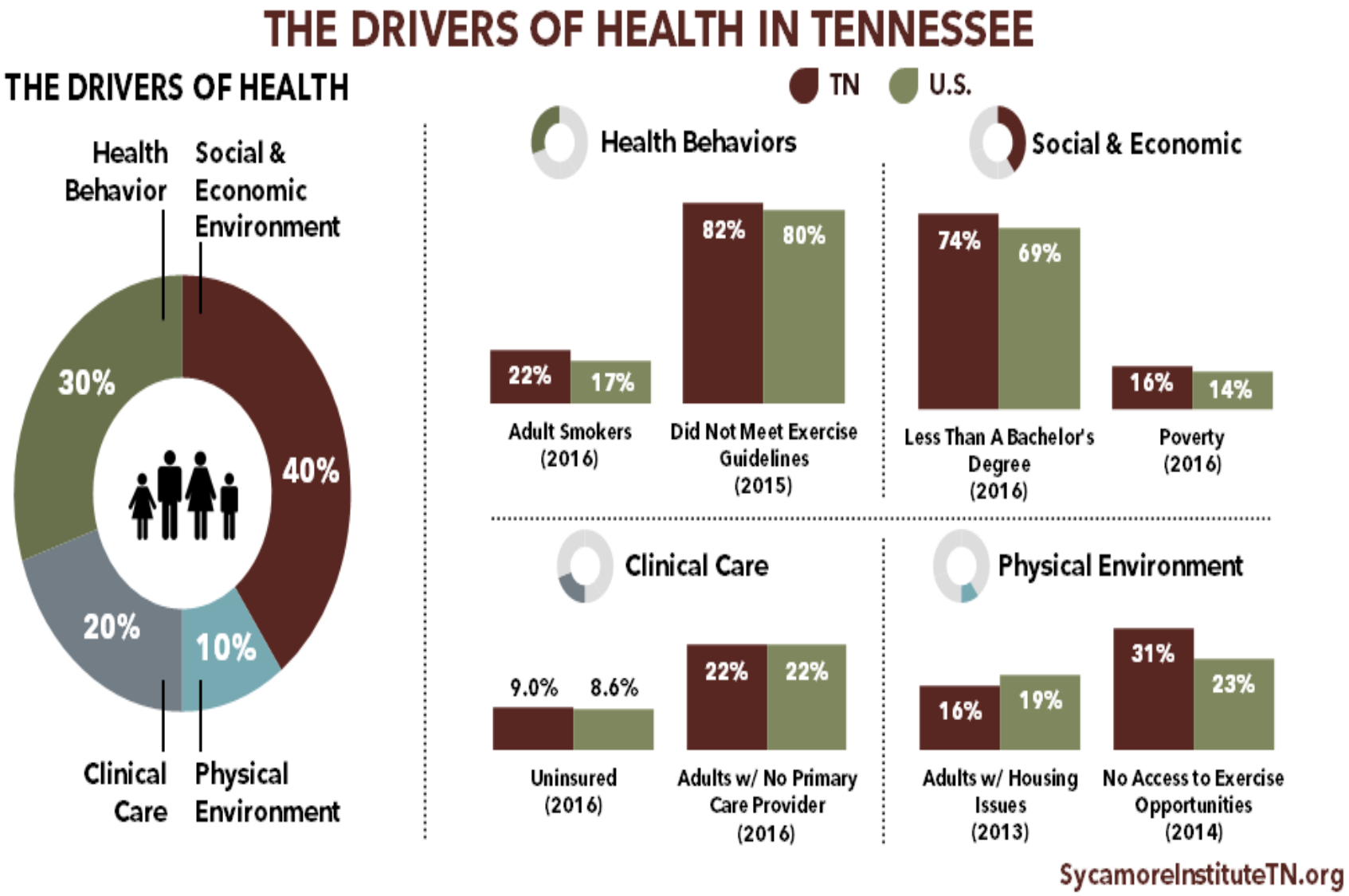


REALITY	EQUALITY	EQUITY	JUSTICE
One gets more than is needed, while the other gets less than is needed. Thus, a huge disparity is created.	The assumption is that everyone benefits from the same supports. This is considered to be equal treatment.	Everyone gets the support they need, which produces equity.	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.

What roots have you supplied?

Root Causes

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



Health disparities in Tennessee

Fall 2020

Analysis of health disparities in Tennessee

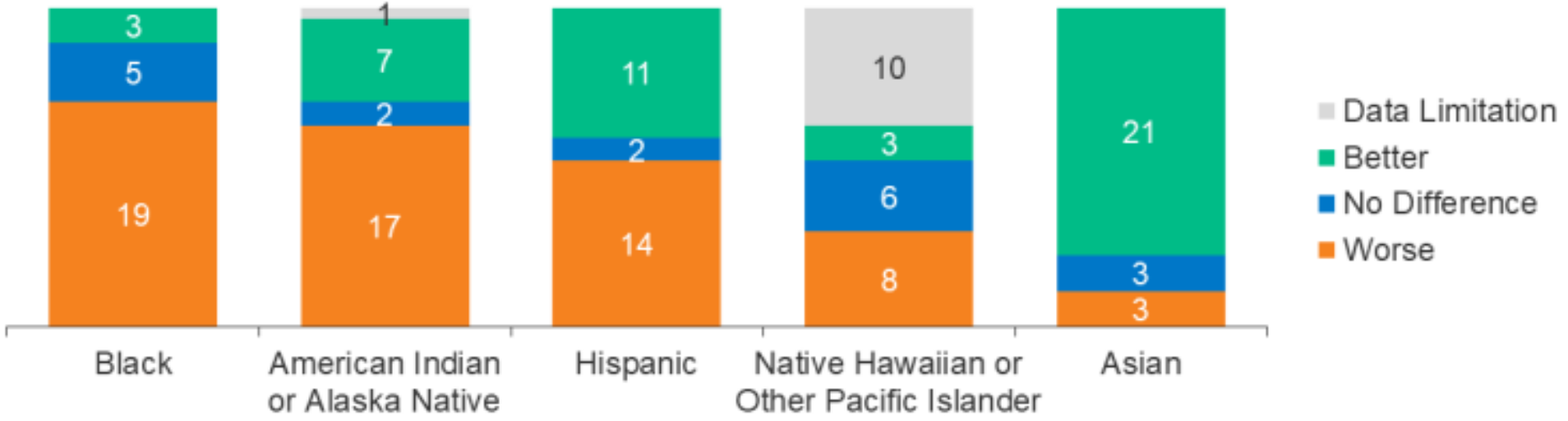
- The social and economic environment contributes more to disparities in health than any other factors
- These determinants are rooted in historical systems, laws, and mandates that limited access to healthcare and resources for some groups
- Historically, public health crises have had a disproportionate 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:



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.

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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

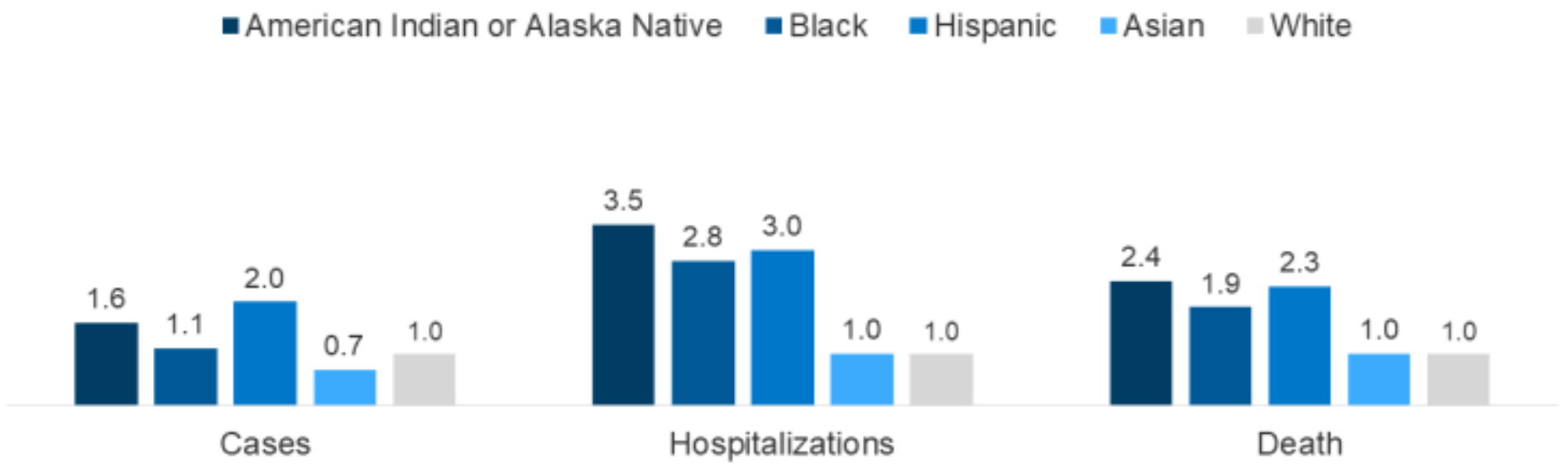
- In Tennessee:
  - Black Tennesseans constitute 17% of the state population; yet they account for 20% of COVID cases and 36% of deaths
  - Latinx Tennesseans constitute 5% of the state population; 35% of COVID cases and 10% of deaths
  - 24% of total cases in TN are marked "pending" for race/ethnicity

Despres, 2020- Salud America!; Young, 2020- TN Justice Center

Figure 4

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:



NOTE: Persons of Hispanic origin may be of any race but are categorized as Hispanic; other groups are non-Hispanic.

SOURCE: CDC, Risk for COIVD-19 Infection, Hospitalization, and Death by Race/Ethnicity, as of 5/12/2021, www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html, accessed 5/12/2021.

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Health Disparities and CHS

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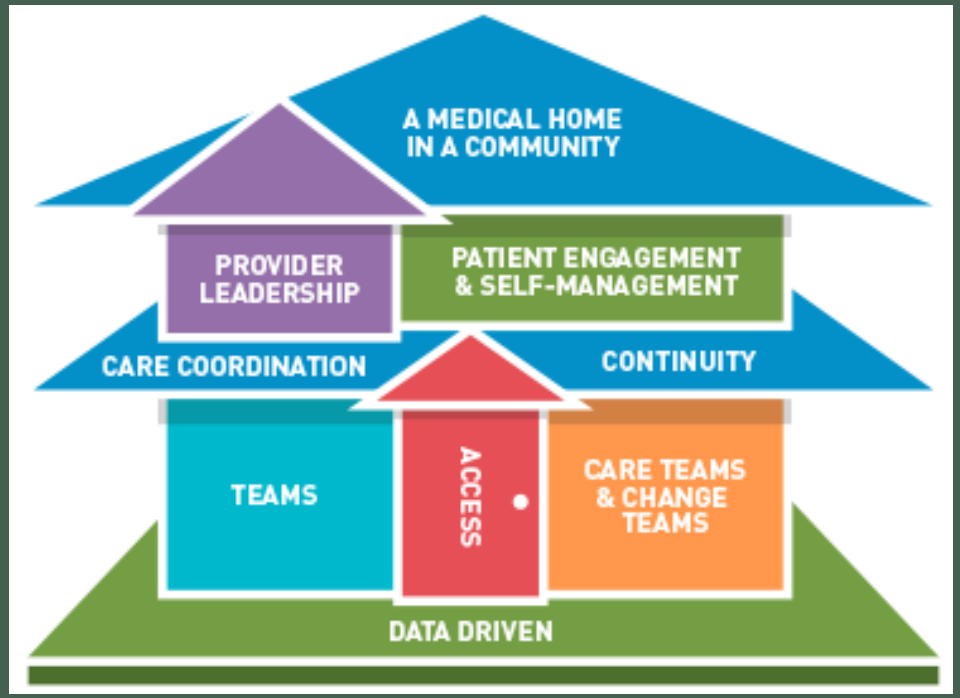
Integrated care and health equity

- 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

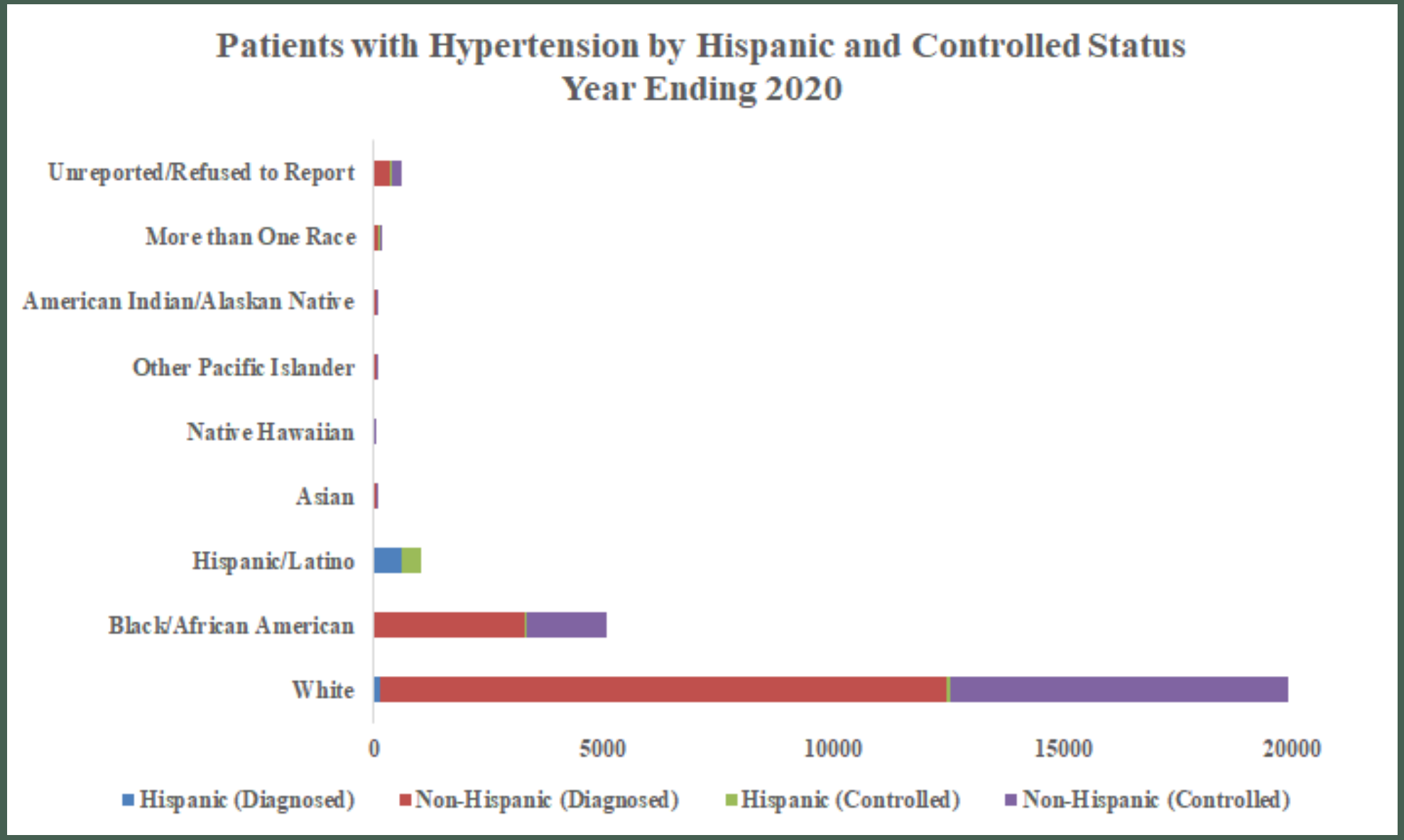


Hypertension in 2019

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

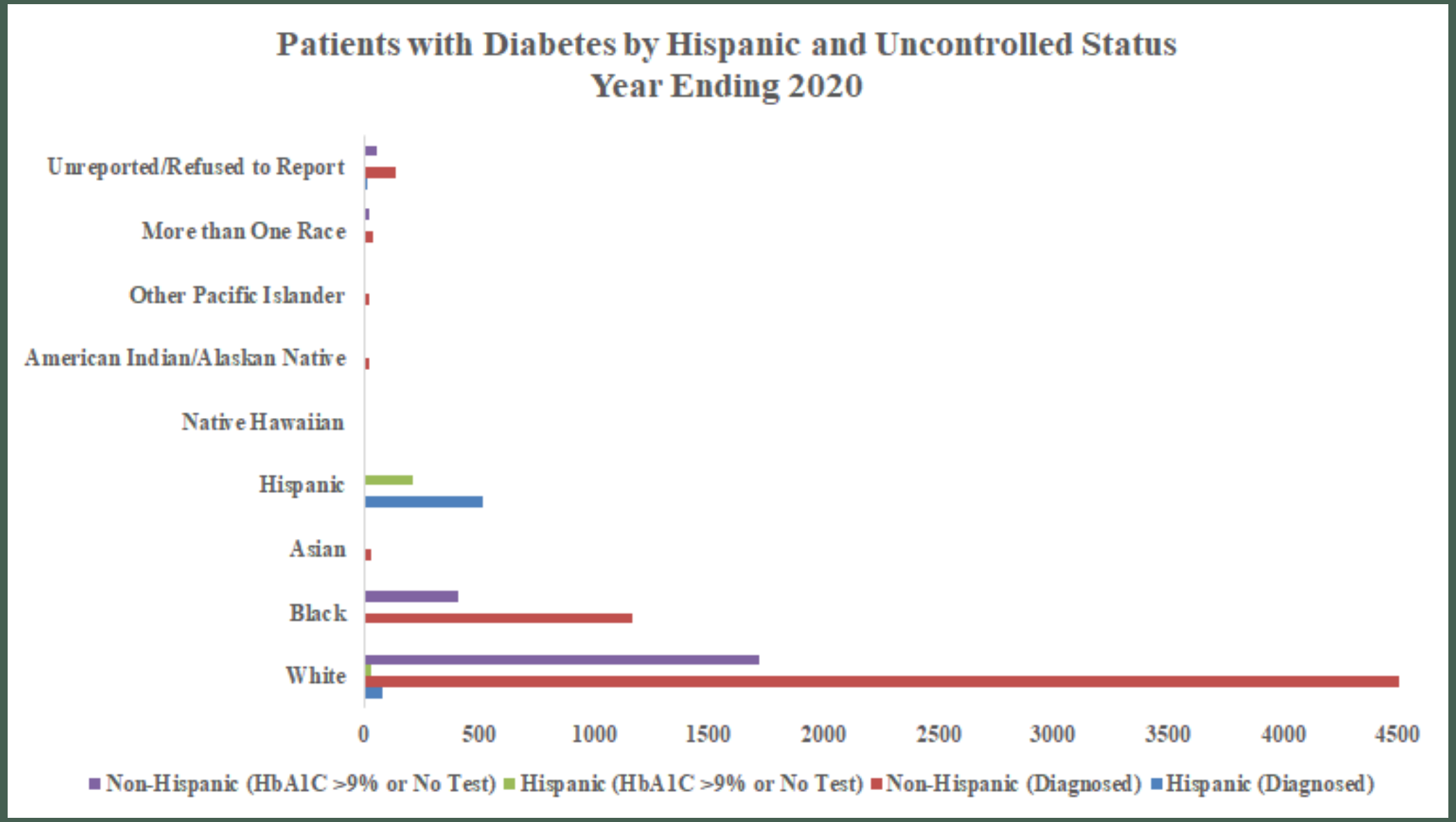
Hypertension in 2019, continued

Group	Total Cases	HTN Cases	Percentage of cases
Patients who are migrants	247	168	68.02%
Patients living in public housing	3676	2298	62.51%
Patients experiencing homelessness	1880	1801	59.97%
Patient Total	15541	10005	64.38%


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
0
5000
10000
15000
20000
Hispanic (Diagnosed)
Non-Hispanic (Diagnosed)
Hispanic (Controlled)
Non-Hispanic (Controlled)

Diabetes in 2019

Group	Total Cases	Diabetes Cases	Percentage of cases
Patients who are migrants	202	120	59.41%
Patients living in public housing	1515	1034	68.25%
Patients experiencing homelessness	725	472	65.1%
Patient Total	6764	4537	67.08%


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
0
500
1000
1500
2000
2500
3000
3500
4000
4500
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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