Confronting Health (In)Equity: Addressing the Social Determinants of Health

Part 1

Presenters:
Lenora Reid, CCSI
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Ruth Colón-Wagner, NYAPRS
James Rodriguez, McSilver Institute for Poverty Policy and Research
• What are the Social Determinants of Health (SDOH)?
• Inequity in the United States
• Approaches to Overcome Inequities
WHAT ARE THE SOCIAL DETERMINANTS OF HEALTH (SDOH)?
“Factors that contribute to a person’s current state of health. These factors may be biological, socioeconomic, psychosocial, behavioral, or social in nature.”
# SOCIAL DETERMINANTS OF HEALTH

We Get Sick and Heal in our Community

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<tr>
<th>Economic Stability</th>
<th>Neighborhood and Physical Environment</th>
<th>Education</th>
<th>Food</th>
<th>Community and Social Context</th>
<th>Health Care System</th>
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<td>Housing</td>
<td>Literacy</td>
<td>Hunger</td>
<td>Social integration</td>
<td>Health coverage</td>
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<td>Income</td>
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<td>Language</td>
<td>Access to healthy options</td>
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<td>Community engagement</td>
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<td>Debt</td>
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<td>Support</td>
<td>Walkability</td>
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**Health Outcomes**

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations
SOCIAL DETERMINANTS OF HEALTH

We Get Sick and Heal in our Community

Adapted from: Schroeder, Steven. We Can Do Better – Improving the Health of the American People"
INEQUITY IN THE UNITED STATES

Some Data
BEHAVIOR IS NOT THE WHOLE STORY...

“Inequities in health and avoidable health inequalities arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces.”

Historical events and policies have led to contemporary social problems and structural inequities that continue to negatively impact and plague people of color and other vulnerable populations.

- Eugenic Laws – forcing more than 60,000 individuals, deemed “mentally ill” or “mentally deficient” in the U.S. to be sterilized. (Stern, 2016).

- Genocidal dispossession of America’s Native American (Indian) inhabitants. (Lum, 2010).

- “Three-Fifths Compromise” – The U.S. Constitution legally institutionalized slavery and deemed African-Americans to count as only 3/5 of a person for census purposes.

- Practice of redline zoning – Institutionalized segregation and caused concentration of poverty in certain areas. (Settles, 1996).
INCOME INEQUALITY – NET WORTH
Racial, Ethnic Wealth Gaps Have Grown Since the Great Recession

Median net worth of households, in 2013 dollars

Notes: Blacks and whites include only non-Hispanics. Hispanics are of any race. Chart scale is logarithmic; each gridline is ten times greater than the gridline below it. Great Recession began Dec. ’07 and ended June ’09.
Source: Pew Research Center tabulations of Survey of Consumer Finances public-use data

PEW RESEARCH CENTER
• In 2013, rates of premature death (before age 75) from stroke and coronary heart disease were higher among non-Hispanic blacks than whites.

• Infant mortality rate for non-Hispanic black women was more than double that for non-Hispanic white women.

• Homicide rates were 665% (6.5 X) higher among non-Hispanic blacks compared with non-Hispanic whites.

• Women, minority racial/ethnic groups (except API), the less educated, non-English dominant and people with disabilities more likely to report:
  - Poor self-rated health
  - More physically unhealthy days,
  - More mentally unhealthy days

• Adolescent birth rates for non-Hispanic black and Hispanic teenage girls is roughly twice that for non—Hispanic whites and Asian/Pacific Islanders.
• Minorities, foreign-born person, and persons who speak language other than English are more likely to live near highways, suggesting increased exposure to traffic air-pollution.

• Unemployment much higher among Blacks, Hispanics, and American Indian/Alaska Natives than among whites in 2006 and 2010.
  o Unemployed adults were much less likely than employed adults to report their health as excellent or very good.

• Highest percentage of adults not completing high school were Hispanic, persons at <1.9% of the federal poverty level, those with a disability, or foreign-born.

• Highest percentage of adults living below the poverty level were non-Hispanic black or Hispanic, those with less than a high school education, those with a disability or foreign born.
Racial and ethnic minorities are:

- less likely to have access to MH services than Whites
- less likely to receive needed care
- more likely to receive poor quality care
- more likely than Whites to delay or fail to seek mental health treatment
- less likely to receive inadequate treatment for anxiety and depression

What contributes to these disparities?

- Lack of access in general
- Lack of insurance
- Provider discrimination
APPROACHES TO OVERCOME INEQUITIES
APPROACHES TO CARE TO OVERCOME INEQUITIES

COMMON ELEMENTS:
- Egalitarian Relationships
- Collaboration
- Empowerment
INTERPERSONAL LEVEL

Overlap Between Patient-Centered Care and Cultural Competence

**Patient-Centered Care**
- Curbs hindering behavior such as technical language, frequent interruptions, or false reassurance
- Understands transference/countertransference
- Understands the stages and functions of a medical interview
- Attends to health promotion/disease prevention
- Attends to physical comfort

**Cultural Competence**
- Understands and is interested in the patient as unique person
- Uses a biopsychosocial model
- Explores and respects patient beliefs, values, meaning of illness, preferences and needs
- Builds rapport and trust
- Finds common ground
- Is aware of own biases/assumptions
- Maintains and is able to convey unconditional positive regard
- Allows involvement of friends/family when desired
- Provides information and education tailored to patient level of understanding

(Saha, et al)
ORGANIZATIONAL/SYSTEM LEVEL
Overlap Between Patient-Centered Care and Cultural Competence

Patient-Centered Care
- Convenient office hours/ability to get same-day appointments/short wait times
- Availability of phone appointments or e-mail contact with providers
- Continuity/secure transition between healthcare settings
- Coordination of care
- Ongoing patient feedback to providers
- Attention to physical comfort of patients
- Focus on health promotion/disease prevention

Cultural Competence
- Services aligned to meet patient needs and preferences
- Healthcare facilities convenient to community
- Documents tailored to patient needs/literacy/language
- Data on performance available to consumers
- Workforce diversity reflecting patient population
- Availability and offering of language assistance for patients with limited English proficiency
- Ongoing training of staff regarding the delivery of culturally and linguistically appropriate services
- Partnering with communities
- Use of community health workers
- Stratification of performance data by race/ethnicity

(Saha, et al)
THE PAIR OF ACES
Adverse Childhood Experiences
THOUGHTS, COMMENTS, QUESTIONS
Confronting Health (In)Equity: Addressing the Social Determinants of Health
Part 2

Presenters:
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• What’s at the core of health inequity?
• Moving from Principle to Practice
WHAT’S AT THE CORE OF HEALTH INEQUITY?

**DISPARITIES**
Disproportionality of poor outcomes Disadvantage

**SAMENESS**
Giving everyone the same thing – it only works if everyone is starting from the same place

**FAIRNESS**
Access to the same opportunities – we must first ensure equity before we can enjoy equality

**FREEDOM**
Barriers and limits removed - Justice

**ACCESS**
Feel valued, have opportunities to achieve self-defined success and wellness
MOVING FROM PRINCIPLE TO PRACTICE
MOVING FROM PRINCIPLE TO PRACTICE

Triple Aim of Health Equity

- Implement Health in All Policies
- Expand Understanding of Health
- Strengthen Community Capacity

- Implement a Health in All Policies Approach With Health Equity as the Goal
- Expand Our Understanding of What Creates Health
- Strengthen the Capacity of Communities to Create Their Own Healthy Future

Health in All Policies: A Guide for State and Local Governments was created by the Public Health Institute, the California Department of Public Health, and the American Public Health Association.
KEY FEATURES:
Patient (Person)-Centeredness

WITHIN HEALTHCARE ORGANIZATIONS

Services should be aligned to meet the needs and preferences of the patients, e.g.:
- Coordinated / integrated / continuous
- Convenient / easily accessible
- Attendant to health promotion / physical comfort

WITHIN INTERPERSONAL INTERACTIONS

Provider understands each patient as a unique human being, e.g.:
- Uses biopsychosocial model
- Views patient as person
- Shares power and responsibility
- Builds effective relationship
- Maintains and is able to convey unconditional positive regard
- Is aware of the “doctor as person”
KEY FEATURES:
Cultural Competence

WITHIN HEALTHCARE ORGANIZATIONS
Ability of the health care organization to meet needs of diverse groups of patients, e.g.:
- Diverse workforce reflecting patient population
- Healthcare facilities convenient and attentive to community
- Language assistance available for patients with limited English proficiency
- Ongoing staff training regarding delivery of culturally and linguistically appropriate services

WITHIN INTERPERSONAL INTERACTIONS
Ability of a provider to bridge cultural differences to build an effective relationship with a patient, e.g.:
- Explores and respects patient beliefs, values, meaning of illness, preferences and needs
- Builds rapport and trust - finds common ground
- Is aware of own biases/assumptions
- Is knowledgeable about different cultures
- Is aware of health disparities and discrimination affecting minority groups
- Effectively uses interpreter services when needed
• Creating Communities of Opportunity

• Focus on Prevention
  o Emphasizing Access
  o How to we get everyone in?
  o How do we keep people in?
Specific Targets:

• Early Childhood Development Initiatives
• Reducing childhood poverty
• Enhancing income and employment opportunities among Youth and Adults
• Improving Neighborhood and Housing Conditions
Specific Targets:

• Ensuring Access of Care for All
• Emphasize Primary Care
• Eliminating Inequities in the Receipt of High-Quality Care
• Addressing Patients’ Social Risk Factors and Needs
• Diversifying the Healthcare Workforce

Williams and Cooper, 2019
STRATEGY THREE –
Raising Awareness of Inequities and Building Political Will to Address them

Specific Targets:

• Increase awareness that racial inequities exist
• Building political support to address inequities
• Increase Public Empathy
• Enhancing Individual and Community Capacity
• Dismantling Racism

Williams and Cooper, 2019
WHAT DOES THIS MEAN FOR ME (OR US)?

• Practice universal prevention – treat everyone “as if” you understand that they are affected by inequities

• Work on life role goals (not only focus on symptom reduction)

• Collect data to ensure that you are providing access

• Collect data to ensure that you are providing quality

• Think about ways to creatively provide opportunities

Williams and Cooper, 2019
THOUGHTS, COMMENTS, QUESTIONS
END

Session 2