Health Equity

Amy Reid, MPH
Director
areid@ihi.org | @_amyjreid_
Agenda

1. What is health equity?

2. How does health equity relate to patient safety & health care quality?

3. What can you do to advance health equity?
Agenda

1. What is health equity?

2. How does health equity relate to patient safety & health care quality?

3. What can you do to advance health equity?
What is Health Equity?

When all people have “the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance”.

CDC
What is Health Equity?

“A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

Healthy People 2020
What is Health Equity?

A difference or disparity in health outcomes that is systematic, avoidable, and unjust.
What is Health Care Equity?

“Racial or ethnic differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention”

IOM, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, 2003
Why?
Why?

What are the key contributors to observed inequities in health & health care?

• Differential access to resources and opportunity
• Differential application of care practices
• Multi-level – individual, community, state, policy
• -isms that marginalize populations (racism, sexism, heterosexism, etc)
• Implicit Bias
Population specific inequities

- Communities of color
- People with disabilities
- Low-income individuals and families
- People experiencing homelessness
- Limited English Proficient people
- LGBTQ+
Inequitable Care & Health Outcomes

- Minority groups (except Asians) more likely to report health as fair or poor.
- Infant mortality for blacks 2.5 times higher than for whites.
- Low-income and uninsured adults are less likely to rate the quality of their care as excellent or very good.
- Blacks are 3 times as likely to die from asthma than whites.
- American Indian/Alaska Natives twice as likely to have diabetes.
- Homeless populations experience unsafe discharges.
- Black women have lower rates of breast cancer but are more likely to die from the disease.
- Women with disabilities are less likely to receive screenings for breast and cervical cancer.
- Blacks are 10 times more likely to have AIDS; Hispanics are 3 times as likely.
- American Indian/Alaska Natives twice as likely as whites to have frequent mental distress.
- 2.5 times more Hispanics as whites report having no doctor.
- Adolescents and adults with disabilities are more likely to be excluded from sex education.
- LGBT inequities related to oppression and discrimination - youth more likely to be homeless, 2-3 times as likely to attempt suicide, lack health insurance and lack knowledgeable health care providers.

References:
- HealthyPeople 2020.
Inequities are harm.
Agenda

1. What is health equity?

2. How does health equity relate to patient safety & health care quality?

3. What can you do to advance the work?
“The lack of a reduction in disparities in either usage or outcomes [for TJR] over an 18-year period is sobering.”

- Jasvinder A Singh & colleagues

QUALITY DISPARITIES: Blacks received poorer quality of care across many National Quality Strategy priorities

Number and Percentage of Quality Measures for Which Blacks Experienced Disparities Compared With Whites

<table>
<thead>
<tr>
<th>Category</th>
<th>Better</th>
<th>Same</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (n=224)</td>
<td>104</td>
<td>104</td>
<td>104</td>
</tr>
<tr>
<td>Patient Safety (n=28)</td>
<td>11</td>
<td>91</td>
<td>12</td>
</tr>
<tr>
<td>Person-Centered Care (n=34)</td>
<td>14</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td>Care Coordination (n=19)</td>
<td>4</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>Effective Treatment (n=46)</td>
<td>19</td>
<td>20</td>
<td>7</td>
</tr>
<tr>
<td>Healthy Living (n=90)</td>
<td>52</td>
<td>28</td>
<td>10</td>
</tr>
</tbody>
</table>

Agency for Healthcare Research and Quality (AHRQ)
Postoperative sepsis per 1,000 adult discharges with an elective operating room procedure, by insurance status and patient race/ethnicity, 2008-2011

Key: API = Asian or Pacific Islander.
Denominator: All elective hospital surgical discharges for patients age 18 years and over with length of stay of 4 or more days, excluding patients admitted for infection, those with cancer or immunocompromised states, those with obstetric conditions, and admissions specifically for sepsis.
Note: Acute care hospitalizations only. For this measure, lower rates are better. Rates are adjusted by age, sex, age-sex interactions, comorbidities, major diagnostic category (MDC), diagnosis-related group (DRG), and transfers into the hospital. White, Black, and API are non-Hispanic. Hispanic includes all races.
People with a usual source of care whose health providers sometimes or never asked for the patient’s help to make treatment decisions, by race, 2002-2013, and stratified by number of chronic conditions, Blacks and Whites, 2013

Note: For this measure, lower rates are better. Number of chronic conditions is assessed for adults age 18 and over. MEPS title for this measure: People with a usual source of care who sometimes or never asked person to help make decisions when there was a choice between treatments. The chronic condition classification list created by Hwang and colleagues is included in the references (Hwang, et al., 2001).
Adults age 65 and over who received potentially inappropriate prescription medications during the calendar year, by race/ethnicity and family income, 2002-2012

Note: For this measure, lower rates are better. Prescription medications received include all prescribed medications initially purchased or otherwise obtained as well as any refills. White and Black are non-Hispanic. Hispanic includes all races. For more information on inappropriate medications, see The American Geriatrics Society 2012 Beers Criteria Update Expert Panel. American Geriatrics Society updated Beers Criteria for potentially inappropriate medication use in older adults. J Am Geriatr Soc 2012 Apr;60(4):616-31.
Adults with mechanical adverse events associated with central venous catheter placement, by age and race, 2009-2012


Denominator: Selected discharges of hospitalized patients age 18 years and over with central venous catheter placement.

Note: For this measure, lower rates are better. Mechanical adverse events include allergic reaction to the catheter, tamponade, perforation, pneumothorax, hematoma, shearing off of the catheter, air embolism, misplaced catheter, thrombosis of embolism, knotting of the pulmonary artery catheter, and certain other events. White and Black are non-Hispanic. Data for age 85+ for 2012 did not meet the criteria for statistical reliability.
Long-stay nursing home residents experiencing use of restraints, by sex, age, and race/ethnicity, 2011-2012

Key: NHOP = Native Hawaiian or Other Pacific Islander; AI/AN = American Indian or Alaska Native.
Source: Centers for Medicare & Medicaid Services, Minimum Data Set 3.0, 2014.
Denominator: Long-stay residents, who are defined as having a cumulative stay greater than 100 days.
Note: For this measure, lower rates are better. The measure was calculated as follows: Percentage of long-stay residents who are physically restrained on a daily basis. In 2011, the top 5 State achievable benchmark for restraint use was 0.7 percent. The States that contributed to the achievable benchmark were Kansas, Maine, Nebraska, New Hampshire, and Vermont.
What is Implicit Bias?

Subconscious prejudicial beliefs or unrecognized stereotypes impact our behavior and we’re unaware of it.

- Normal cognitive process
- Result of how we are socialized
- Shapes expectations, how information is shared, how we act, how we communicate verbally and nonverbally, and what we recommended
Differences in care recommendations

- Equally likely to diagnosis CAD and angina across gender and race variables but more likely to refer men and white patients to cardiac catheterization than women or black patients.

- Black race and Hispanic ethnicity were independent risk factors for amputation, even more so than a history of rest pain or gangrene.

- Across many cancer types, survival differences between blacks and whites dissipated when patients were comparably treated for similar stage cancers.

Shulman et al. The effect of race and sex on physicians’ recommendations for cardiac catheterization. 1999
Collins et al. Lower extremity nontraumatic amputation among veterans with peripheral arterial disease: is race an independent factor?. 2002
Bach et al. Survival of blacks and whites after a cancer diagnosis. 2002
Population specific inequities: LGBTQ+
Population specific inequities: LGBTQ+

- Disrespectful treatment, providers’ lack of awareness, care denial, blaming of sexual orientation/gender identity for illness, violence in health care settings
- >50% medical school curricula include no information on LGBTQ+ care
- Extreme poverty

To Dos:
- Understanding population, clinical setting, resources and support, medical education
- Questions about sexual health, sexual orientation, gender identity
- Make no assumptions
- Collect SOGI data

National LGBT Health Education Center
Population specific inequities: LGBTQ+

- What is your current gender identity? (check ALL that apply)
  - Male
  - Female
  - Transgender Male/Trans Man/FTM
  - Transgender Female/Trans Woman/MTF
  - Gender Queer
  - Additional Category (please specify)
  - __________

- What sex were you assigned at birth? (Check One)
  - Male
  - Female
  - Decline to Answer

- What is your preferred name and what pronouns do you prefer (e.g. he/him, she/her)?
Staff Experience and Safety & Quality

- Good staff management, climate of trust and respect = higher quality care

- The greater the proportion of staff from a black or minority ethnic (BME) background who report experiencing discrimination at work in the previous 12 months, the lower the levels of patient satisfaction.

- The number of both BME and white staff who are praised by management after raising a concern is 3% BME 7.2% for white staff.

- 24% of BME staff compared to 13% of white staff did not raise a concern for fear of victimization.

NHS England Staff Satisfaction Survey Q23b

Percentage of white and BME staff experienced discrimination at work from Manager / team leader or other colleagues
Small Group Discussion

1. How does health equity apply in your setting? Who in your system receives poorer quality of care and experiences poorer outcomes?
2. What is the state of addressing health equity at your organization?
3. What challenges do you see to advancing health equity in your setting?
Agenda

1. What is health equity?

2. How does health equity relate to patient safety & health care quality?

3. What can you do to advance health equity?
# Health Equity as a System Property


## 1. Make health equity a strategic priority
- Demonstrate leadership commitment to improving equity at all levels of the organization
- Secure sustainable funding through new payment models

## 2. Develop structure and processes to support health equity work
- Establish a governance committee to oversee and manage equity work across the organization
- Dedicate resources in the budget to support equity work

## 3. Deploy specific strategies to address the multiple determinants of health on which health care organizations can have a direct impact
- Health care services
- Socioeconomic status
- Physical environment
- Healthy behaviors

## 4. Decrease institutional racism within the organization
- Physical space: Buildings and design
- Health insurance plans accepted by the organization
- Reduce implicit bias within organizational policies, structures, and norms, and in patient care

## 5. Develop partnerships with community organizations
- Leverage community assets to work together on community issues related to improving health and equity
What will you do when you go home?

1. Further explore my own biases
   https://implicit.harvard.edu/implicit/takeatest.html
2. Advance conversations in my organization
3. Educate team members
4. Review our policies/practices/data collection with an equity lens
5. Review stratified data
6. Plan tests of change based on inequities in our system
Q & A
Integrating Equity into your Strategic Plan