MI Cultural Competency Training – *Health Equity Essentials 2024*

meridian

Learning Objectives

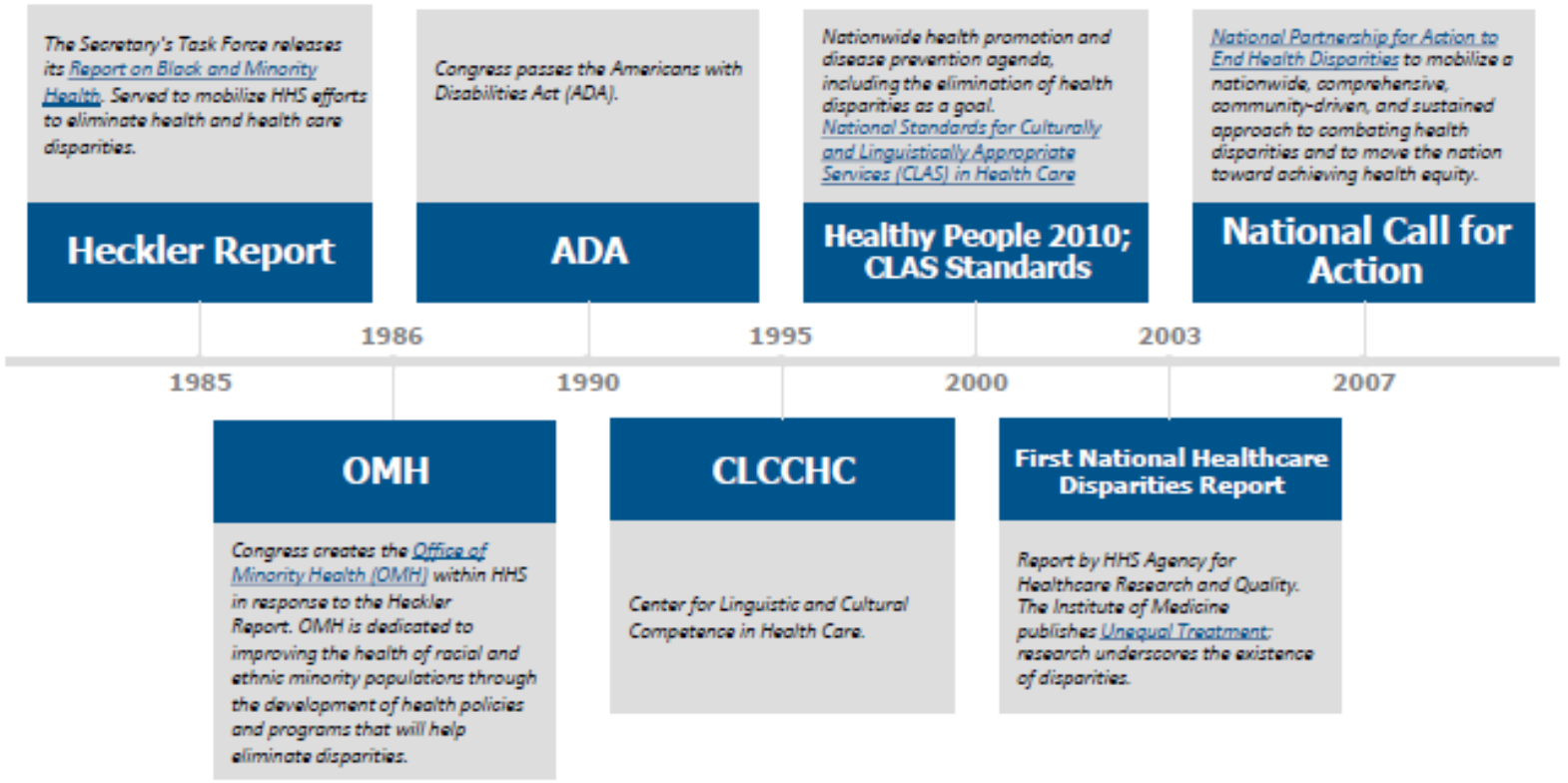
- Explore the history of health equity and why it matters for all.
- Define health equity and related terms.
- Discuss what creates health.
- Identify root causes of health inequities.
- Describe ways to advance health equity and mitigate barriers to achieving health equity.

Health Equity Key Points

WHAT HEALTH EQUITY IS	WHAT HEALTH EQUITY IS NOT
Inclusiveness	Divisiveness
Accountability	Blame
Equity	Equality
Justice	Oppression
Quality/Value-based	Waste/Increasing cost
Improving health	Worsening disparities

Health Disparities Timeline

Early History 1985-2007



Source: U.S. Department of Health & Human Services. (n.d.). *Health Equity Timeline*. Think Cultural Health. https://thinkculturalhealth.hhs.gov/clas/health-equity-timeline.

Health Disparities Timeline

Recent History 2010 and Beyond

- 2010-Patient Protection and Affordable Care Act
- 2010-Healthy People 2020

Institutional Initiatives:

- Centers for Health Equity
- Expansion of Diversity, Equity,& Inclusion offices
- Leadership roles within organizations (Chief Health Equity, Health Equity Officer, etc…)
- Health Disparity Task Forces (e.g., Covid-19)

Key Terms

Health Equity: when every person has the opportunity to attain their highest level of possible health without disadvantage because of social position or other socially determined circumstance.

Health Disparities: a population-based difference in health outcomes.

- A particular type of health difference that is closely linked with social or economic disadvantage

These differences adversely impact groups of people who have systematically experienced greater obstacles to health, based on their:

racial or ethnic group	Mental Health
Religion	Age
Socioeconomic status	Sexual orientation or gender identify
Gender	Geographic location
Cognitive, sensory, or physical disability	Other characteristics historically linked to discrimination

Disparities occur across the life course, from birth, through mid-life, and among older adults.

Health Inequities: differences in determinants and health outcomes that are the result of social and structural imbalances that are avoidable and preventable.

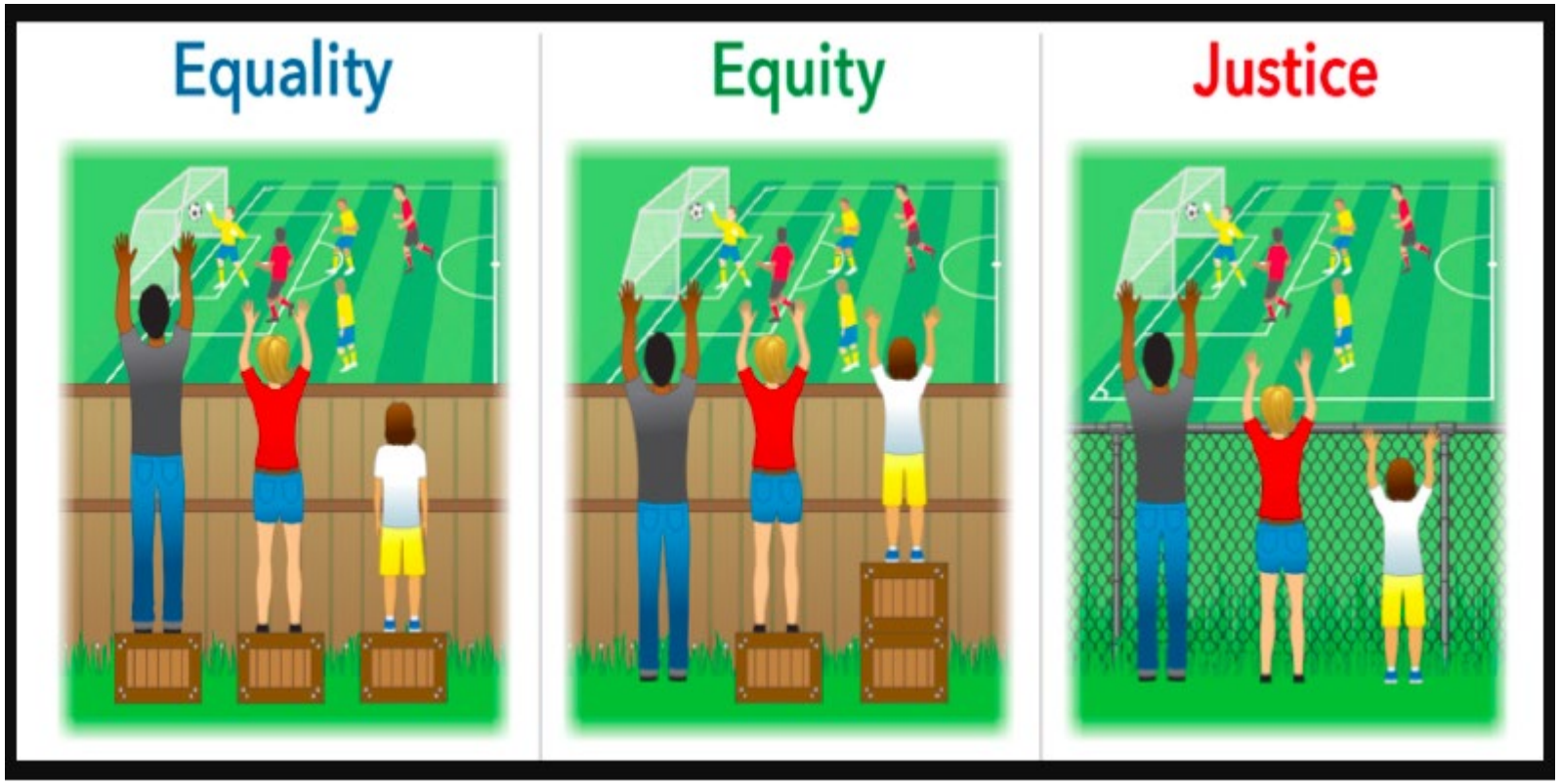
Determinants of Health/SDoH: the conditions in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks.

Structural inequities: the personal, interpersonal, institutional, and systemic drivers-such as racism, sexism, classism, able-ism, xenophobia, and homophobia-that make those identities salient to the fair distribution of health opportunities and outcomes.

Structural Racism: a system of structuring opportunity and assigning value based on phenotype ("race"), that:

- unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, undermines realization of the full potential of the whole society through the waste of human resources.

Equality - Equity - Justice



What is Cultural Competency?

Cultural Competency is defined as a set of consistent *behaviors, attitudes, and policies* that come together in an organization, agency, or among professionals that enables effective work in cross-cultural situations.

It refers to the ability to **honor** and **respect** the *beliefs, language, interpersonal styles and behaviors* of individuals and families receiving services, as well as staff who are providing such services.

What is Diversity?

Encompasses unique *beliefs*, *values*, and *customs*. Refers to people with many different cultures living and working around each other.

Understanding the WHY

Cultural Humility Plays an Important role in how we relate to one another:

- Cultural Humility starts with a commitment to understanding and working to overcome power imbalances in:
  - the healthcare system
  - society as a whole and
  - in interactions with members
- Use awareness to cultivate *sensitive* and *responsible* approaches to member interactions and services.

Interactive Discussion – Let's Think Deeper!

- **Case Study:** *Higher rate of childhood obesity & asthma in certain zip code.*

    - Limited grocery stores and healthy food options.
    - Safety of streets limits outdoor physical activity.
    - Scarce green space; highway intersects neighborhood.
    - Increased pollution from bus depot, traffic, and nearby landfill.
    - Limited bus schedule makes work flexibility difficult for those who don't own a car.
    - Neighborhood discriminatory practices (such as redlining) reduced investments into area.
    - … and the list goes on

Interactive Discussion – Let's Think Deeper!

Case Study: *Maternal/Infant Mortality-Intersection of Racism, Sexism, and Chronic Stress*

- Black mothers die from childbirth at ~ 3x the rate of White mothers.
    - Post-partum bleeding or embolisms
    - Preeclampsia and eclampsia
    - Infections/complications from surgery
    - **Access to quality healthcare**
    - **Underlying chronic health conditions**
    - **Educational and social economic factors***
    - **Implicit bias & discrimination in providing care**

- *Weathering hypothesis:* repeated exposure to socioeconomic adversity, racism, and perpetual discrimination can harm health. The health of Black women may begin to deteriorate in early adulthood as a physical consequence of cumulative socioeconomic disadvantage.
- *Allostatic load*.
- ***Even when SDoH are addressed, disparities still exist. Black women with at least a college degree had higher severe complication rates than women of other races and ethnicities who never graduated high school.***

Impact of Health Inequities

- Poor health outcomes / increased disease burden
- Lower life expectancy
- Decreased productivity and employment
- Pushes ~100 million people into poverty each year (worldwide)
- Increase levels of:
  - *Stress*
  - *Anxiety*
  - *Crime*
  - *Violence*
- Difficulty containing infectious outbreaks
- Inefficient healthcare system
- Direct and indirect medical care expenditures (~$93 billion per year in excess medical care costs, $42 billion in lost productivity; raises cost of healthcare for everyone)

Significance for Health Equity in Healthcare Systems

- ✓ Reduce avoidable medical cost by reducing health disparities that drive up cost for specific population groups.
- ✓ Improve service and quality through targeted health equity/Disparity reduction projects.
- ✓ Robust health equity strategies and initiative outcomes can be improved through access to care.

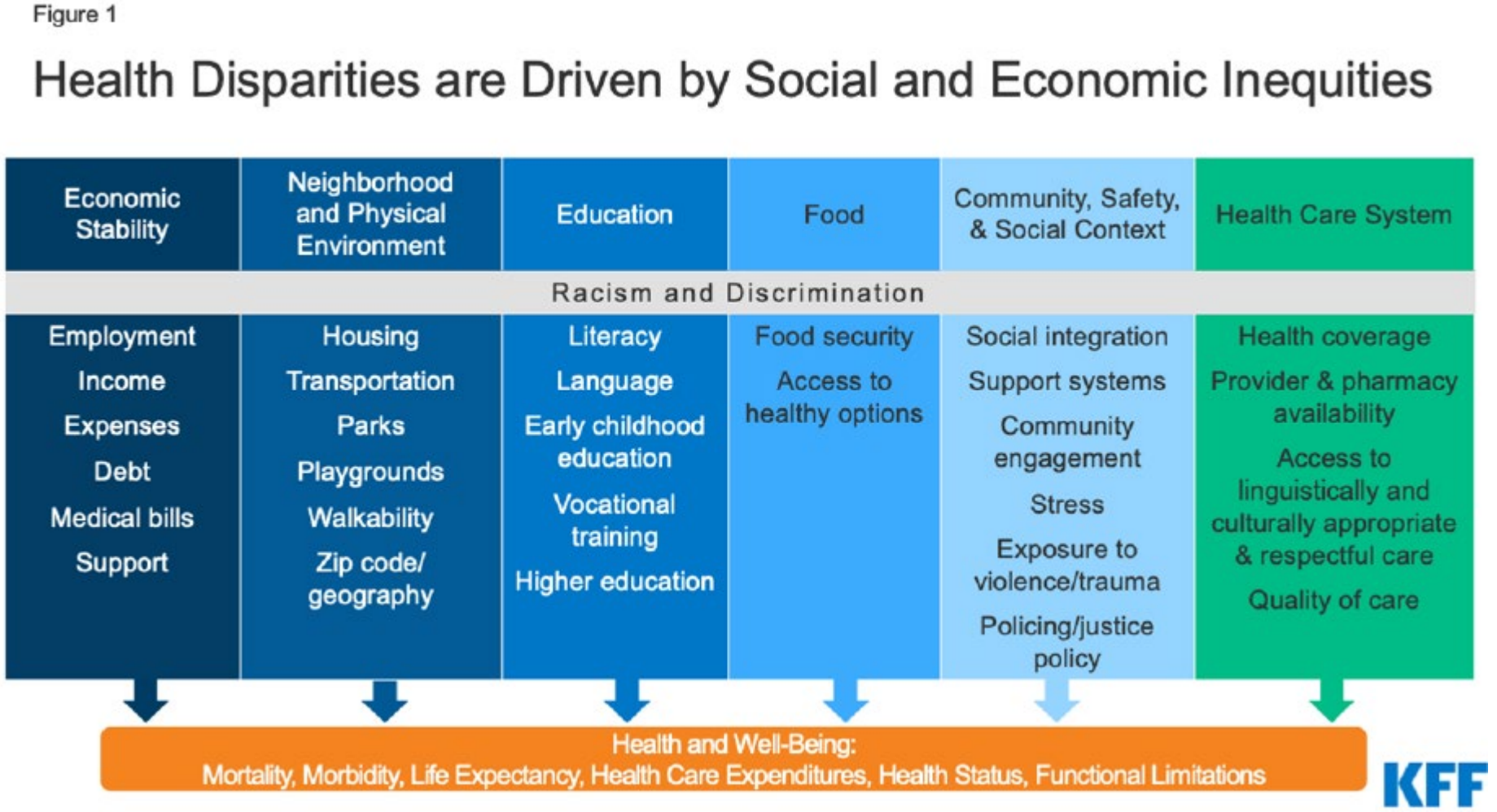
Root Causes of Health Inequities

Foundational Process

Root Causes of Health Inequities

Drivers of Health Disparities

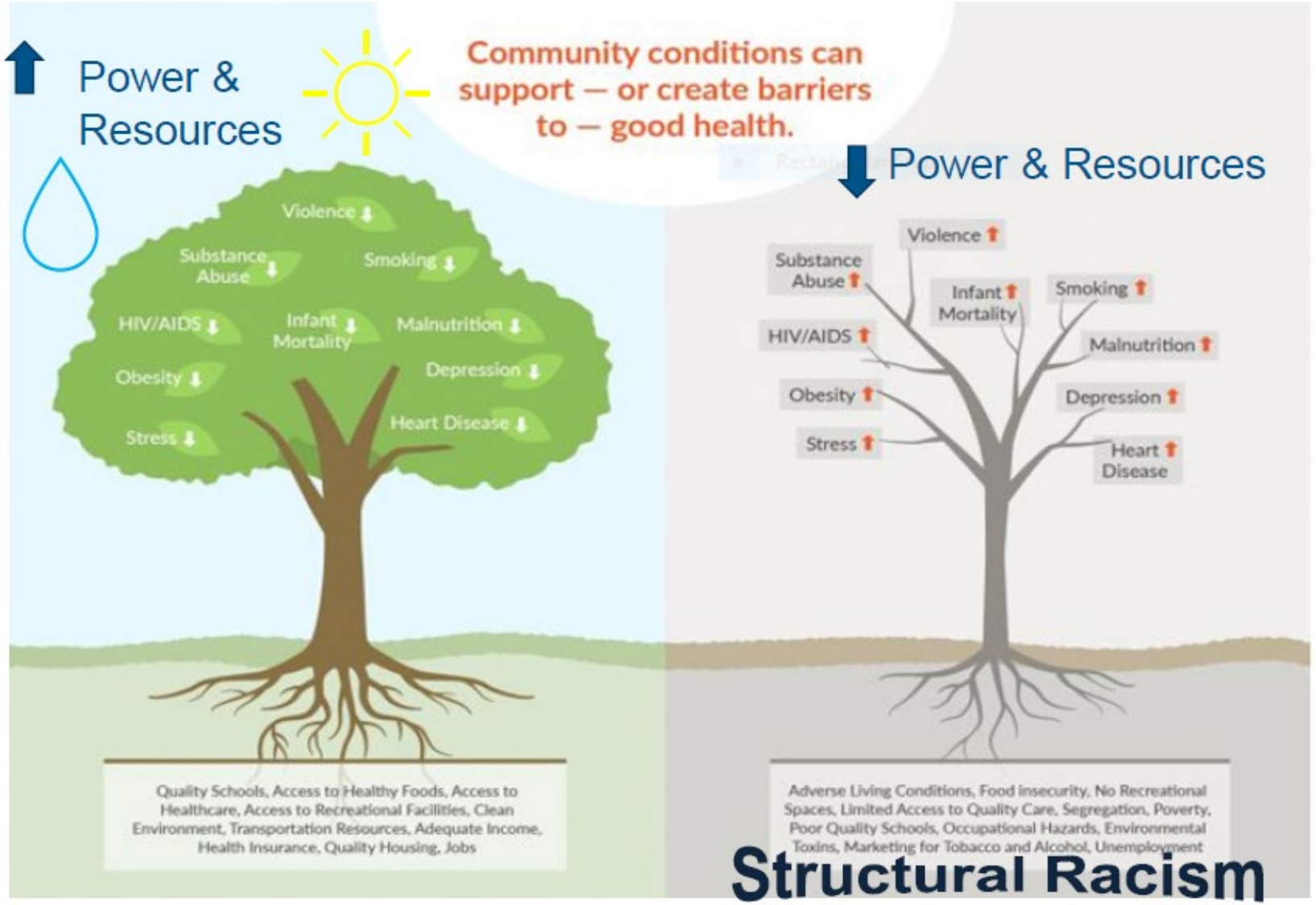
Figure 1



Ndugga, N., & Artiga, S. (2021, May 11). *Disparities in health and health care: 5 key questions and answers*. KAISER FAMILY FOUNDATION. https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-healthcare-5-key-question-and-answers/

Root Causes of Health Inequities

Uncovering Root Causes



Adapted from: Ramirez, L. K. B., Baker, E. A., & Metzler, M. (2008). Promoting health equity: A resource to help communities address social determinants of health. Social Determinants of Health Work Group at the Centers for Disease Control and Prevention, US Department of Health and Human Services.

Root Causes of Health Inequities

Digging Deeper into Root Causes

- The root cause of health disparities is unequal distribution of power and resources. Structural racism is a ***major driver***.
- Policies and processes across various sectors that are structured (intended or not) to benefit living conditions or opportunities of certain groups over others.
- Discrimination in the following are all at the root of inequities (importance of addressing SDoH):
  - Education
  - Employment
  - Housing
  - Transportation
  - + urban and regional planning
- Insurance coverage, access to quality, culturally competent services.
- To address the poor outcomes we see in certain communities (e.g., maternal/infant mortality, emergency room usage or COVID-19 disparities), root causes must be addressed.

- *Bailey, Z. D., Feldman, J. M., & Bassett, M. T. (2020). How Structural Racism Works — Racist Policies as a Root Cause of U.S. Racial Health Inequities. New England Journal of Medicine, 384(8), 768–773. https://doi.org/10.1056/nejmms2025396*
- *Bailey, Z. D., Krieger, N., Agénor, M., Graves, J., Linos, N., & Bassett, M. T. (2017). Structural racism and health inequities in the USA: evidence and interventions. Lancet (London, England), 389(10077), 1453–1463. https://doi.org/10.1016/S0140-6736(17)30569-X*
- *Groos M, Wallace M, Hardeman R, Theall KP. (2018). Measuring inequity: a systematic review of methods used to quantify structural racism. J Health Dispar Res Pract, 11, 190-206.*

Triple Aim of Health Equity

Health in <u>all</u> policies

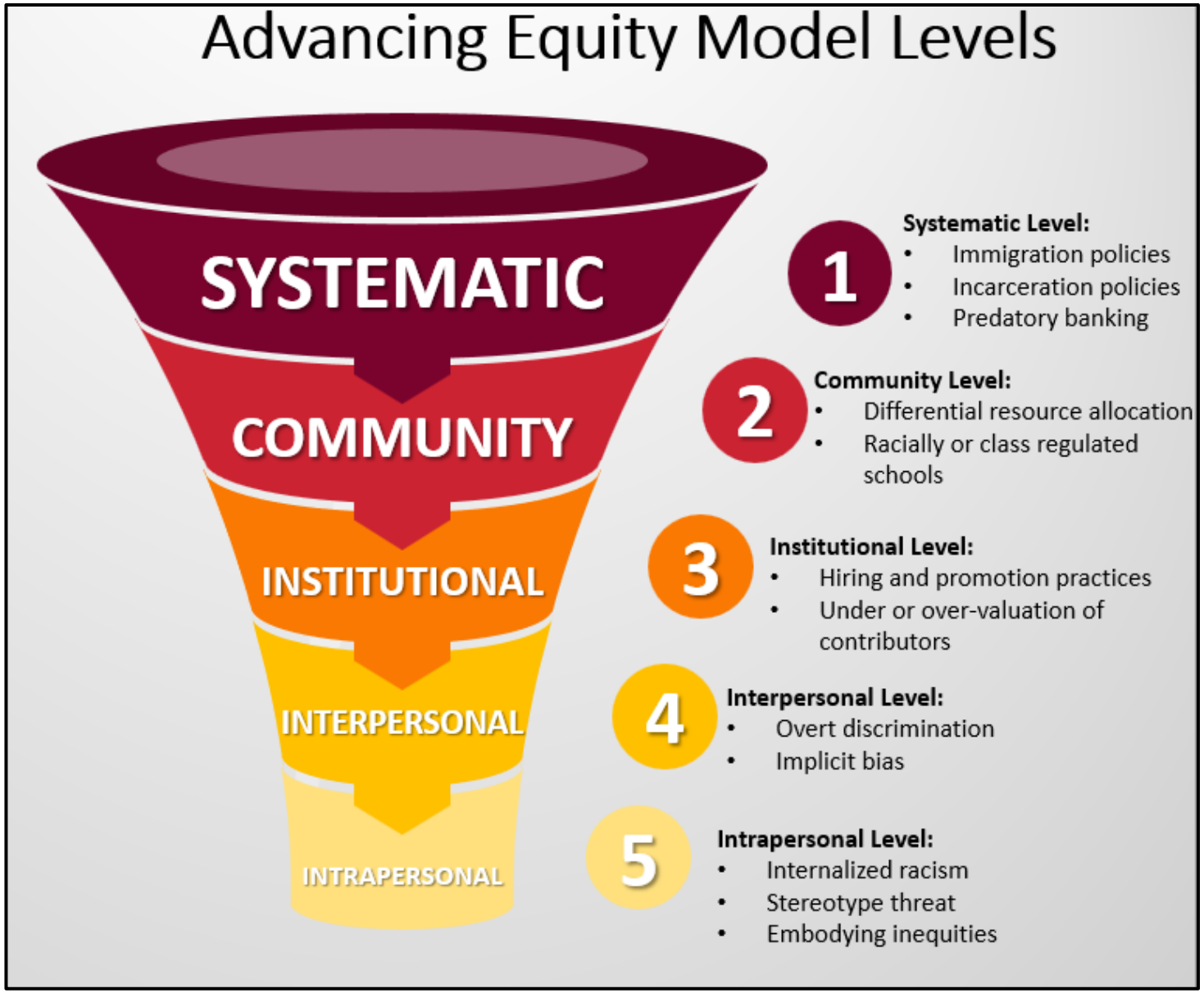
Expand understanding of what creates health

Strengthen community capacity

Guiding Principles (5Cs)

- ***Commitment:***
  - Health equity goals included in critical documents (mission statement, strategic plan, policies).
  - "Believe" and "Do".
  - Avoid *tokenism*.
- ***Courage:***
  - Create a brave space where health equity is not the exception, but the rule.
  - Leadership courage and political will to call out and be intentional about eliminating racism and other forms of discrimination.
- ***Culture:***
  - Health equity lens in ***all*** work.
  - Cultural humility.
  - CLAS standards.
  - Make it "the business of everyone."
- ***Collaboration:***
  - internal and external stakeholder buy-in.
  - Full transparency with shared power with community.
- ***Cost:***
  - dedicated budget to support equity work.
  - Sustainable funding (e.g. philanthropy, new payment models; leveraging and re-aligning existing resources).

Social Ecological Model in Advancing Equity

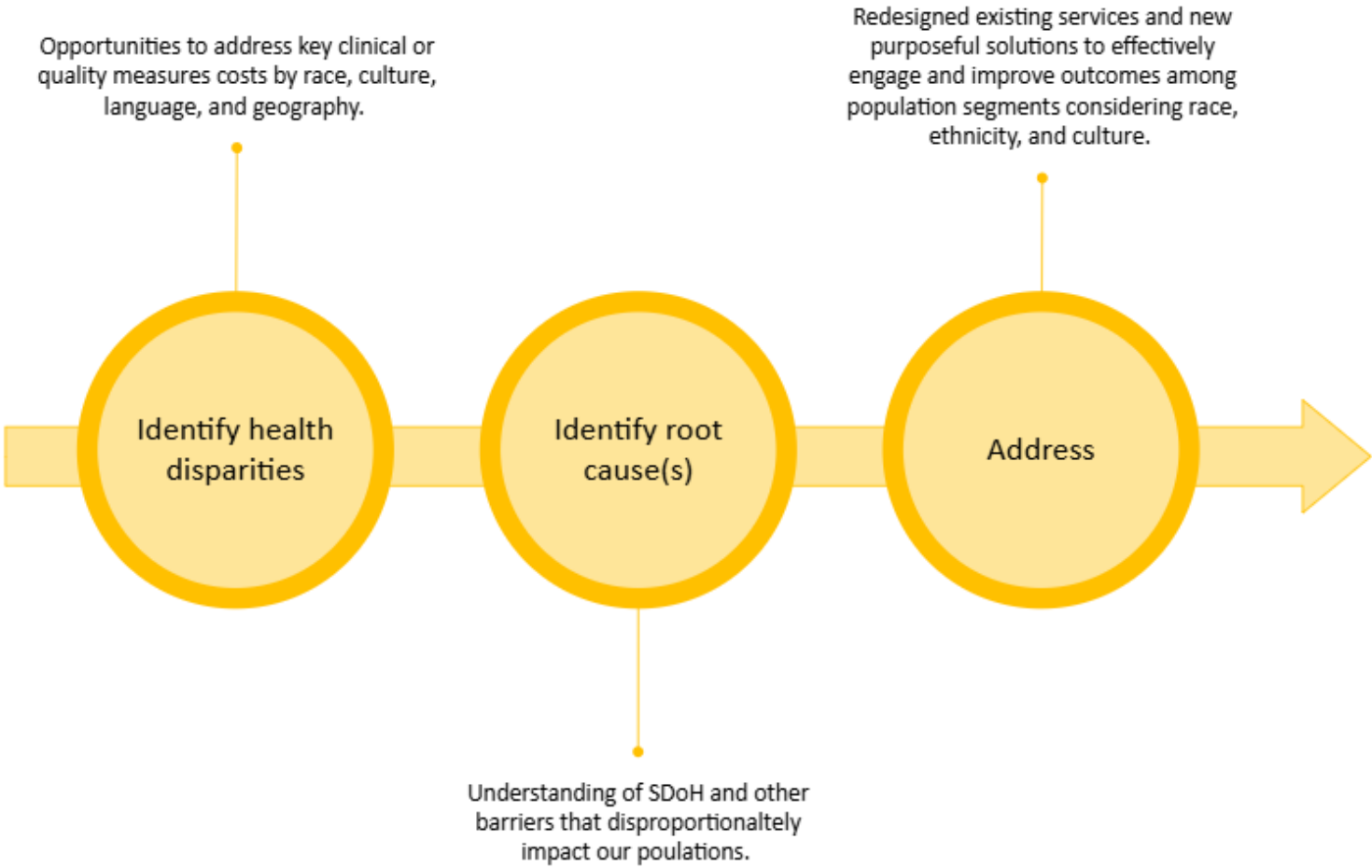


McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An Ecological Perspective on Health Promotion Programs. Health Education Quarterly, 15(4), 351–377. https://doi.org/10.1177/109019818801500401

Health Equity Initiatives

- **Staff committees, groups, councils**
  - *(i.e.: Diversity, Equity, & Inclusion, SDoH)*
- **Community health initiatives in your area**
- **Culturally and Linguistically Appropriate Services (CLAS)**
- **Population Health Management Efforts**
  - (*e.g., Community Help Lines, Aunt Bertha)*
- **Meridian Population Health Pod Development**

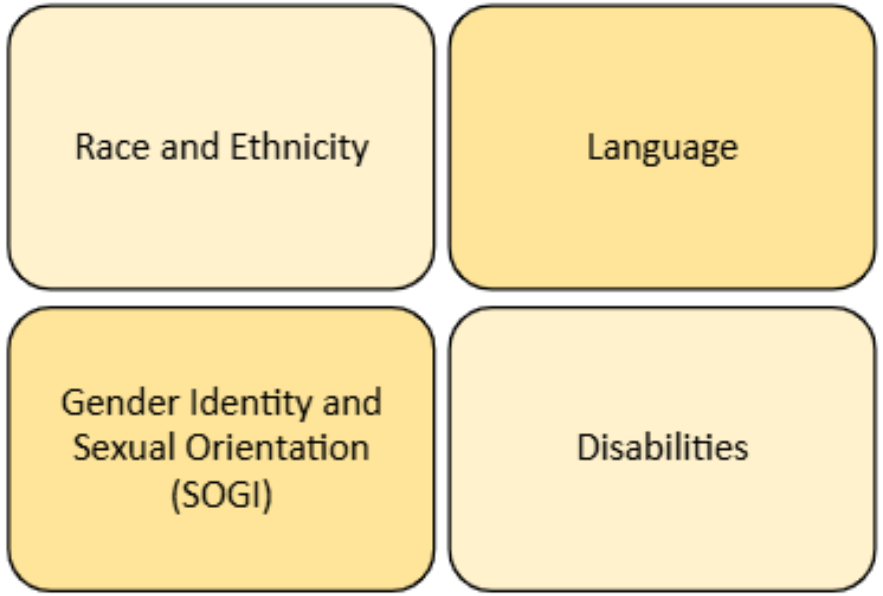
Operationalizing Health Equity



Opportunities for Improvement

- Increase diversity in leadership & governance; supplier diversity
- Require training for compliance
- Self-work & accountability
- Build trust and collaboration with members and community

Please remain cognizant of diverse communities and take proactive steps to minimize disparities related to:



Conditions That May Qualify as Disparities

- Autism
- AIDS/HIV, and its symptoms
- Alcoholism
- Asthma
- Blindness or other visual impairments
- Cancer
- Cerebral palsy
- Depression
- Deafness or hearing loss
- Diabetes
- Epilepsy
- Hearing or speech impairments
- Heart Disease
- Intellectual disabilities
- Loss of body parts
- Major Depressive Disorder
- Migraine Headaches
- Mobility disabilities (requires use of wheelchair, walker, or cane)
- Multiple sclerosis
- Muscular dystrophy
- Orthopedic impairments
- Paralysis
- Complications from Pregnancy
- Post-Traumatic Stress Disorder
- Traumatic Brain Injury
- Thyroid gland disorders
- Tuberculosis

Certain temporary, non-chronic impairments of short duration with little or no residual effects usually are not disabilities. Likewise, environmental conditions and alternative lifestyles are not protected. A person currently engaging in the illegal use of drugs is not considered an individual with a disability. This refers both to the illegal use of unlawful drugs such as cocaine as well as prescription drugs.

Sexual Orientation & Sexual Identity

Terminology

Term	Gender	Gender Identity	Gender Expression
Definition	• A person's biological sex • Culture may ascribe certain feelings, behavior and attitudes	• One's sense of being a man, woman, or other gender	• How a person expresses their gender • Via appearance, personality, behavior

Term	Lesbian	Gay	Bisexual	Transgender	Questioning	Plus (+)
Definition	Female same-sex attraction, sexual behavior	Experiences physical, romantic, and/or emotional attractions to same sex	Experiences physical, romantic, and/or emotional attractions to both sexes	One whose gender identity or gender expression differ from their birth sex	One who is questioning their sexual orientation or gender identity	Remaining identities may include: • Intersex • Asexual • Nonbinary

Ethnic Disparities in Health Care

- Black Americans are 60% more likely to be diagnosed with Diabetes and twice as likely to die from diabetes than white Americans.
- Hispanics have higher rates of obesity than non-Hispanic whites.
- Black Parents are two times more likely to have an infant die by their first birthday.
- Racial and ethnic minority groups in the US experience higher rates of illness and death across a wide range of health conditions, and tend to have a lower life expectancy, when compared to white counterparts.
- African American women are more likely than European American women to die from breast cancer, despite having a lower incidence of the disease.
- Influenza death rates are higher for African Americans and American Indian/Alaska Natives/Native Alaskans than they are for European Americans.

The Surgeon General's Report Mental Health: *Culture, Race and Ethnicity*

Members of racial and ethnic minority populations:

- Are less likely to receive necessary mental health care;
- Often receive a poorer quality of treatment;
- Are significantly underrepresented in mental health research.
- Are less likely to have access to available mental health services;
- Underuse mental health services and are more likely to delay seeking treatment.

Consequently, in most cases, when such individuals seek mental health services they are at an acute stage of illness. This delay can result in a worsening of untreated illness and an increase in involuntary services.

Possible Contributing Factors to Health Disparities

- Fear of being misunderstood or disrespected
- Providers are not familiar with the prevalence of conditions among certain minority groups
- Providers may fail to take into account differing responses to medication
- Providers may lack knowledge about traditional remedies, leading to harmful drug interactions
- Patients may not adhere to medical advice because they do not understand or do not trust the provider
- Providers may order more or fewer diagnostic tests for patients of different cultural backgrounds

Transportation Barriers

- Currently, 3.6 million individuals do not access medical care because they experience transportation barriers.
- Transportation barriers lead to rescheduled or missed appointments, delayed access to care, and missed or delayed medications use.
- Common transportation barriers include long travel distances, lack of vehicle, transportation cost, inadequate infrastructure, and adverse policies affecting travel.
- Meridian is committed to address transportation barriers and building partnerships to improve transportation and health care access for patients and families and create more equitable, healthier communities.

Transportation

Meridian provides two different types of medical transportation for our members. The type transportation used depends on whether the member needs emergency (EMT) or non-emergency medical transportation (NEMT) services.

Emergency Transportation (EMT)

- An emergency is any event that puts the health and life of a Medicaid beneficiary at serious risk without immediate treatment. Medicaid reimburses emergency transportation providers when they furnish services to eligible beneficiaries according to the rules.
- This is used for transporting patients in an emergency and are fully equipped with life-saving equipment and other medical supplies that are equipped for a safe and speedy trip to the nearest hospital.

Non-emergency Medical Transportation (NEMT)

- Non-emergency medical transportation (NEMT) is an important benefit for Medicaid member who need to get to and from medical services but have no means of transportation.
- The Code of Federal Regulations (CFR) requires States to ensure that eligible, qualified Medicaid beneficiaries have NEMT to take them to and from providers.
- This is used for trips that are non-emergency in nature, meaning there is no immediate threat to the health or life of the participant. Members may require NEMT due to lack of a valid driver's license, lack of a working vehicle, geographic isolation, or the inability to take traditional transportation for physical, mental, or developmental reasons.

REAL, SOGI, Disparity Assumptions & Barriers

- *Some assumptions about a member can interfere with the trust and rapport.*
- *Assumptions can also lead to a* lack of competent care*.*
- *Stigma and Mistreatment may lead to:*
  - Insensitivity to needs
  - Refusal of care
  - Inadequate or substandard care

Barriers may lead to…

- *Low comfort in utilizing health care services*
- *Low trust in providers*
- *Difficulty in discussing health concerns or needs*
- *Lack of awareness and low competency*
- *Lack of awareness (for example, in the LGBT community) often overlooked in hospital and provider care education*

Improving Strategies

Create a Welcoming Environment:

- Prominently post the facility's nondiscrimination policy or patient bill of rights
- Show common areas reflecting/being inclusive of all communities ('I Speak' Language cards, LGBTQ+, etc.)
- Be mindful of visitation polices / How requirements may affect specific populations
- Determine mechanisms for handling patient-to-patient discrimination

Positive Impacts of Cultural Competency

- More successful patient education
- Increases in patient's health care seeking behavior
- More appropriate testing and screening
- Fewer diagnostic errors
- Avoidance of drug complications
- Greater adherence to medical advice
- Expanded choices and access to high-quality clinicians

What Is Your Role?

- Think about your role to our members:
  - How do you apply what you learned / discussed in this training to your everyday operations?
  - What is the culture of your office/working environment and supporting these initiatives?

References/Resources

- Americans with Disabilities Act of 1990 (42 U.S.C. § 12101)
- https://www.ada.gov/topics/intro-to-ada/
- Adapted from Relias Learning “A Culture-Centered Approach to recovery”
- https://gaycenter.org/community/lgbtq/
- https://www.census.gov/library/stories/2021/11/census-bureau-survey-explores-sexual-orientation-and-gender-identity.html
- https://www.ada.gov/topics/intro-to-ada/
- Adapted from Centene’s Cultural Awareness in Health Care, 2010
- https://www.ncqa.org/hedis/reports-and research

Questions?

Please contact your Health Plan network representative for any additional questions relating to Cultural Competency.

Thank you
For
your participation

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