OneCare Vermont

Health Equity & Access Population Health Playbook – Best Practice in Decreasing Racial/Ethnic and Other Disparities

Preamble

We have a duty to maximize health equity and access to care by minimizing and deconstructing inherent biases in the practice of medicine. These inherent biases exist in our cultural approach to patients (unintentional discrimination)[i], our clinical calculators (that include race/ethnicity as a risk factor)[ii], our continuous quality work (gaps in under-represented groups can be hidden in quality averages)[iii], and our data sets (under-represented groups are often not included in research data)[iv]. Discrimination usually exists at the system level and requires system level change. However, that does not exclude individual clinicians from the mandate to become more culturally humble, inclusive, and strategic in their clinical practice and panel management.

This playbook is targeted to the Primary Care workforce and presents population health management strategies at the individual provider level to maximize equity and access for all in health care delivery.

Reflection Questions

1. Do you stay current on the current respectful and inclusive terminology? **Inclusive Language Guide**
2. Could you differentiate between demonstrating cultural humility and providing unbiased health care delivery?
3. How have your system and your individual providers innovated in the equity space?
4. Should strategies be different for areas with low vs. high levels of vulnerable populations?
5. How could this playbook be optimized?
6. What is your call to action?

Necessary workforce training (staff and providers):

- Implicit bias
  - **Implicit Bias: What It Is, Examples, & Ways to Reduce It**
  - **Implicit Bias Training — CultureAlly**
- Cultural humility
  - **Embracing Cultural Humility and Community Engagement | Global Health Equity | CDC**

Necessary System-level strategies:

For the patient and their care partners (family, friends, paid aides/home care workers, or others that support the patient in their care):

- Integrated, expanded care teams that are patient-focused, and include care partners
  - Social work to address Heath Related Social Needs (Social Drivers of Health)
    The AHC Health-Related Social Needs Screening Tool
  - Coordination of a Network-wide repository of resources updated in real-time (e.g.: cultural resource guides)
  - Care Management to address high risk and high needs patients
  - Community outreach workers
- Adequate staffing to complete the above
- Collaborate with essential healthcare partners such as the Vermont Department of Health and Vermont Blueprint for Health

For staff and providers:

- Awareness of the intersection and differences between social drivers of health and weathering (the health effects of stress and discrimination)
  - The weathering hypothesis as an explanation for racial disparities in health: a systematic review - ScienceDirect
- Communication with patients and their care partners
  - Translation services (eg: Interpreting & Translation Services)
    - Advertising translation services, gender-affirming care, prenatal care, services for home-based support/caregivers
    - Adequate training of healthcare providers on the use of translation services
  - Portal access
  - Texting patients
- Providing appropriate information and education for care partners

For the providers:

- Protect population management time
- Community-based care (health fairs, time for home visits, mobile clinics, vaccine clinics)
- Equity quality data – sliced by race/ethnicity and other protected statuses (disability included)
  - *Note: Using insurance status as a marker for vulnerability would not be fully inclusive of all at-risk groups*

- Education on inherent bias in medical calculators (e.g., cardiac surgery risk, preeclampsia risk, pulmonary function tests, renal function calculations, and many more)

Proposed individual clinician strategies in Primary Care:
Improving Equity in the PCMH: Primary Care Practices can elevate the care for patients who suffer from healthcare disparities by incorporating some additional steps into existing population health/registry workflows. Consider that patients who have healthcare disparities often rely more on care partners, who may have their own health disparities/challenges.

Teach strategies to use an *equity lens when looking at a primary care patient panel*

- Educate providers on gaps in preventative and chronic care for patients with healthcare disparities – both wellness and specialist visits are lower in these groups.
- Keep aware of biased data and medical calculators when seeing individual patients
- Prioritize wellness visits and closing care gaps
    - Schedule wellness (preventative visit/wellness exam or Medicare Annual Wellness visit) for all patients without a comprehensive exam in the past 12 months
- Consider scheduling more time with patients with Limited English Proficiency
- Remain open to new patients with vulnerable status (e.g.: race/ethnicity, medications for opioid use disorder care, Long COVID care, any learners)
- Understand how to access and provide extra resources (e.g.: transportation, legal assistance, food access, etc.)
- Use population health strategies and alternative outreach (e.g., community health workers) to address care gaps in patients who suffer from healthcare disparities
    - Train providers how to assess their patient panel and identify patients who suffer from healthcare disparities

Teach strategies to *create specialty access*

- Using registries, identify patients high risk health conditions (e.g.: HTN, CAD, CHF, CKD, COPD, CAD, and DM) who could benefit from a specialist referral or further intervention
- Consider how to provide alternative access to specialist care (e.g.: eVisit, telemedicine, in person visit, more PCP visits, health literacy support)
- Review patient list for those who could benefit from a referral to specialist.
- Target outreach to patients and specialty providers to help close chronic disease gaps in care
- Consider means to include care partners in care and communication when appropriate (e.g.: telemedicine, portal access)

References

[i] Leung, L. B., Steers, W. N., Hoggatt, K. J., & Washington, D. L. (2020). Explaining racial-ethnic differences in hypertension and diabetes control among veterans before and after patient-centered medical home implementation. *PLOS ONE*, *15*(10), e0240306. https://doi.org/10.1371/journal.pone.0240306
[ii] [ii] Vyas, D. A., Eisenstein, L. G., & Jones, D. S. (2020). Hidden in Plain Sight — Reconsidering the Use of Race Correction in Clinical Algorithms. *New England Journal of Medicine*, *383*(9). https://doi.org/10.1056/nejmms2004740
[iii] Swietek, K. E., Gaynes, B. N., Jackson, G. L., Weinberger, M., & Domino, M. E. (2020). Effect of the Patient-Centered Medical Home on Racial Disparities in Quality of Care. *Journal of General Internal Medicine*. https://doi.org/10.1007/s11606-020-05729-x
[iv] Ibrahim H, Liu X, Zariffa N, Morris AD, Denniston AK. Health data poverty: an assailable barrier to equitable digital health care. Lancet Digit Health. 2021 Apr;3(4):e260-e265. doi: 10.1016/S2589-7500(20)30317-4. Epub 2021 Mar 4. PMID: 33678589

356 Mountain View Drive, Suite 301, Colchester, VT 05446