



## Framing the Conversation for Greatest Impact

### NC Institute of Medicine

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This session will provide a brief overview of the following;

- ✓ Understanding of disparities and how they manifest.
- ✓ Description of equality versus equity –reframing our thinking.
- ✓ Illustrate the importance and promise of diversity and inclusion.
- ✓ Overview of individual and institutional strategies to address diversity and disparities, and promote equity.

# What diversity do you see?





# Addressing Health Disparities



**National Geographic**

**Diversity in the US 2050**

**How are we going to  
address and talk about  
disparities in the future?**





Why this  
matters...





# What Drives Health and Health Disparities?

## Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment Income Expenses Debt Medical bills Support	Housing Transportation Safety Parks Playgrounds Walkability Zip code / geography	Literacy Language Early childhood education Vocational training Higher education	Hunger Access to healthy options	Social integration Support systems Community engagement Discrimination Stress	Health coverage Provider availability Provider linguistic and cultural competency Quality of care

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



# What are Health Disparities?



Health disparities are the significant differences in disease *incidence, prevalence, morbidity, mortality, and survival* across diverse populations.

Health disparities are the inequalities and inequity that occur in access, use, and provision of healthcare information and services across different racial, ethnic, gender, socioeconomic, and other minority groups.



# **Underrepresented and historically disenfranchised groups tend to have worse health outcomes compared to the general population**







**African Americans and Hispanics tend to receive fewer and less quality of healthcare across a range of disease areas and clinical services.**

**Cancer**

**Cardiovascular Disease**

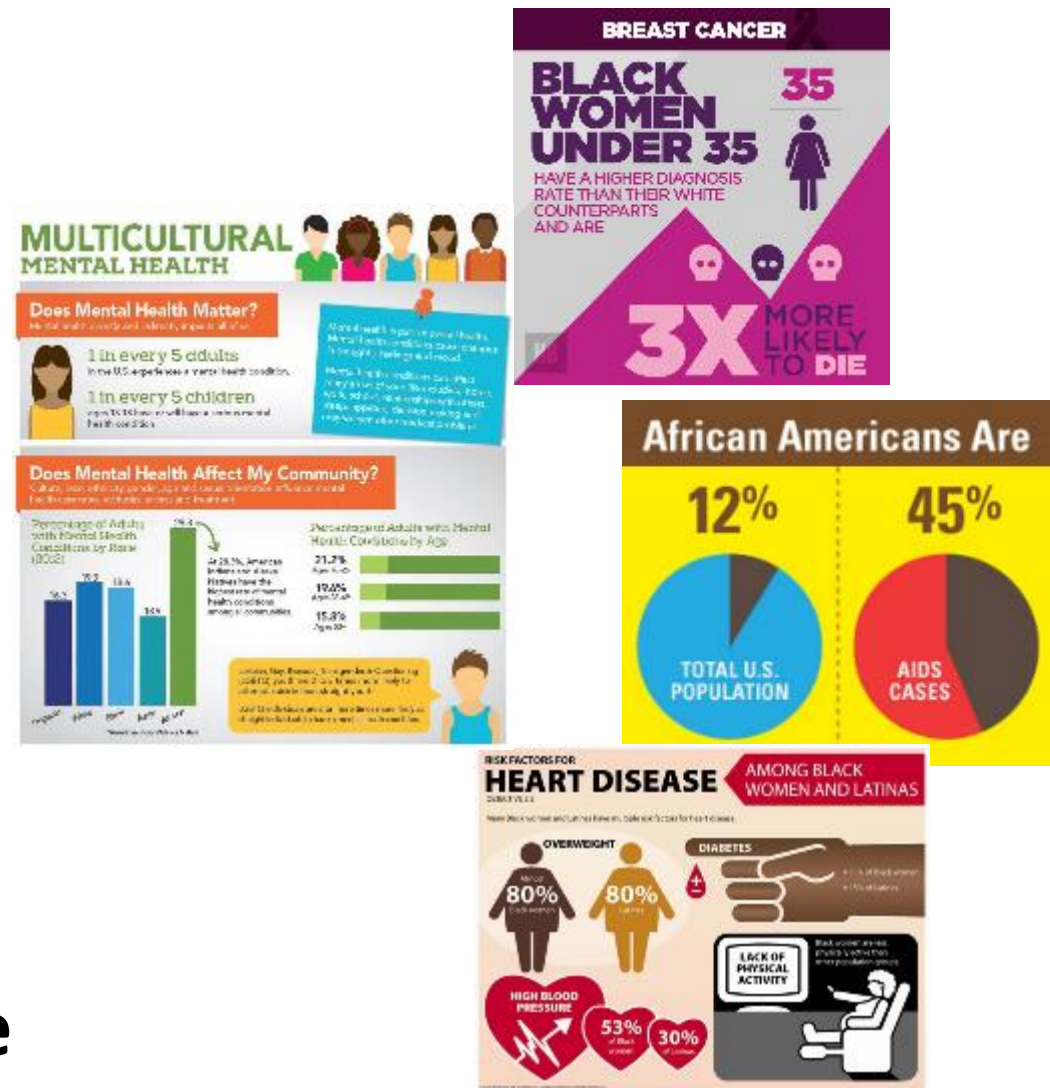
**Diabetes**

**HIV/AIDS**

**Mental Health**

**Pain Management**

**Hospice and End of Life Care**



# Less care and treatment is consistent across various settings

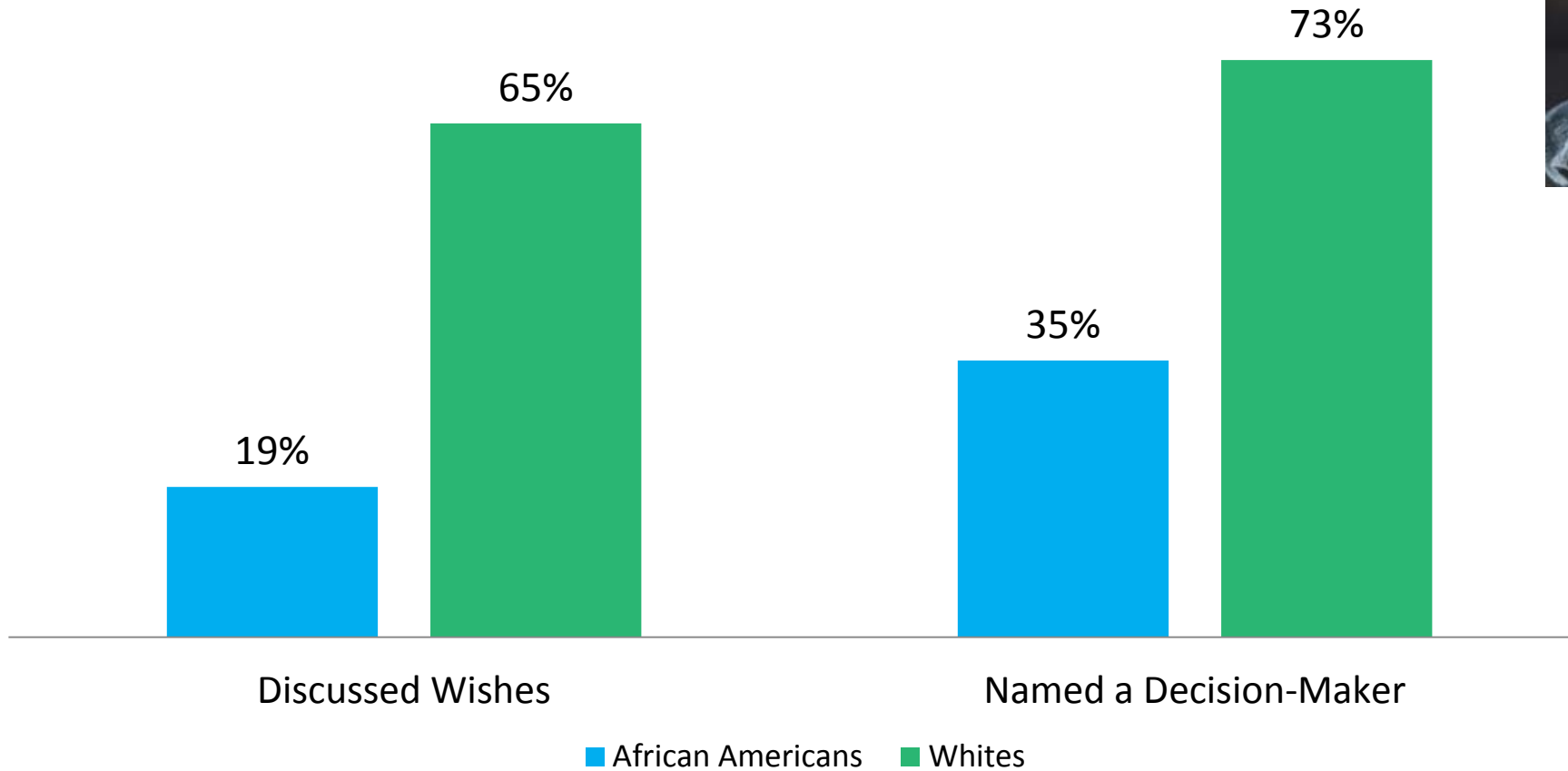


- Disparities remain even when **clinical factors**, such as stage of disease presentation, co-morbidities, age, and severity of disease are taken into account
- Disparities are consistent **across a range of clinical settings**, including public and private hospitals, teaching and non-teaching hospitals, etc.





# Race Disparities in Advanced Care Planning



# ADVANCE CARE PLANNING IS GOOD FOR PATIENTS & FAMILIES

- More likely to get the care they want
- More likely to die comfortably with hospice
- Less likely to spend last months in hospital
- Communication with doctors is better
- Caregivers are less depressed, stressed and anxious after their loved one dies

WHO WILL MAKE MEDICAL DECISIONS FOR YOU IF YOU NO LONGER CAN?

Make sure your health care choices are known



Advance Care Planning



THINK ABOUT IT  
TALK ABOUT IT  
SHARE IT



Your Health  
Your Choice



Find out more at: [www.yourhealthyourchoice.org](http://www.yourhealthyourchoice.org)





Patients who do not participate in advance care planning may not reap the benefits and risk receiving lower quality care.

African Americans experience lower quality care at the end of life than Whites.

*“There should be a point where you talk about what to do in the future. ... before he needs a breathing tube.”*

*“We had talked about it. So that made it easier. The doctor asked me about putting him on the ventilator, I said no. He didn’t want that.”*

## AFRICAN-AMERICAN CAREGIVERS

EQUAL ACP –Stakeholder  
PI: Dr. Kimberly Johnson



## Racial differences in Palliative care Use After A Stroke

- Institution's that served mostly white patients had significantly higher rates of people getting palliative care.
- Hospitals serving predominantly people of color had less use of palliative care after a stroke.



# What is Health Equity?



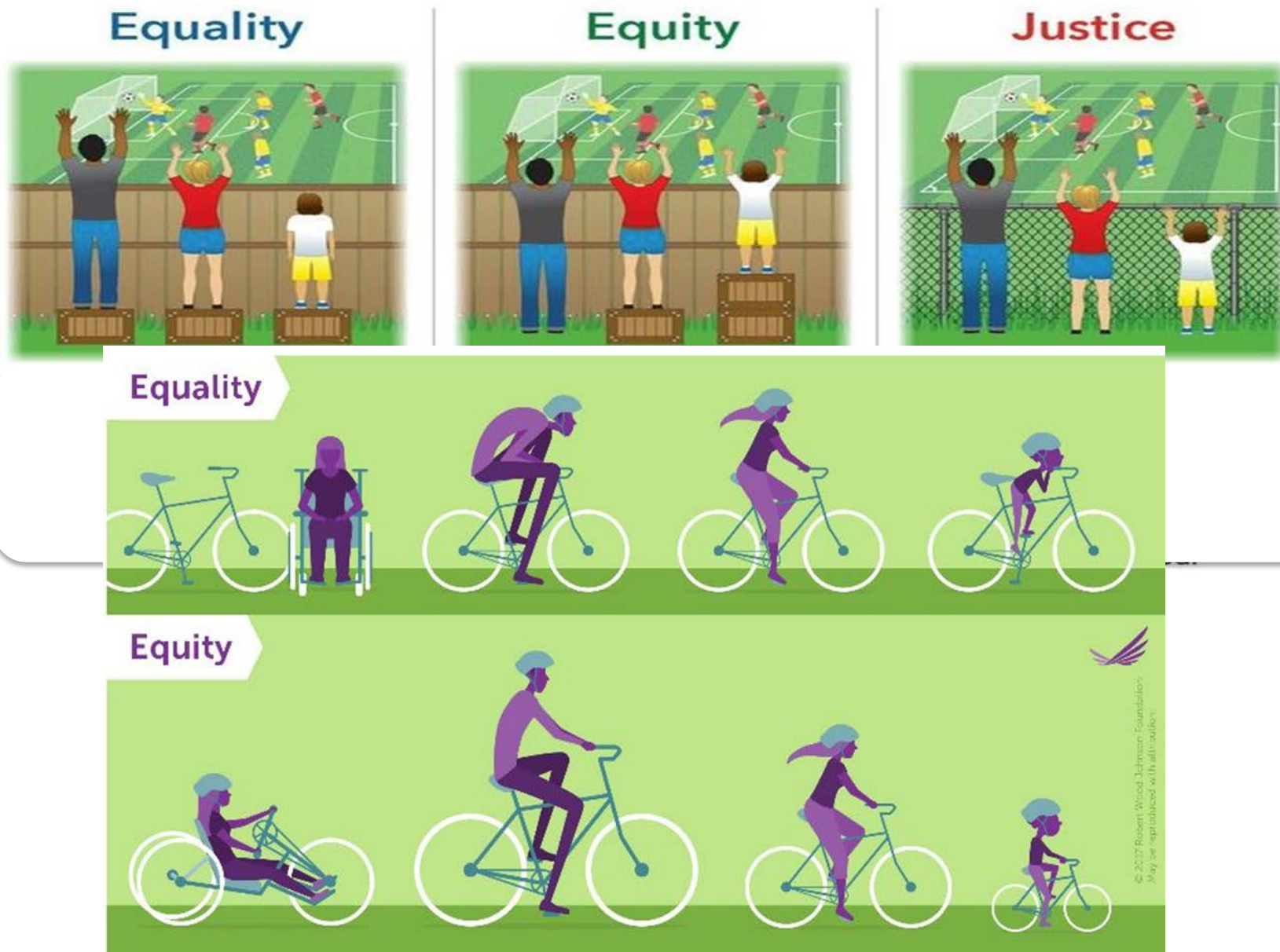
**Health Equity** exists when there are no unnecessary, avoidable, unfair, and unjust, systemically caused differences in health status.

**Health Inequities** result from the unequal structuring of life chances, based on historic, social and economic inequalities; these are built and sustained by societal institutions over time and generations.

# Health Equality and Health Equity



- Race and Ethnic
- Gender
- Rural/ Urban
- Socioeconomic
- LGBTQIA



# Implicit Bias

What do I take for granted?

What are my assumptions about any given group “different” from my own?

In what ways am I the fish in the water?





# Individual and Institutional Level Questions to Ask



- ✓ How do I incorporate a health equity and disparities lens in my work?
- ✓ What steps can I take to ensure my work is informed by diversity, disparities, and advancing health equity?
- ✓ Who is at the table when making decisions?
- ✓ What assumptions am I making, implicit bias?
- ✓ How well do we address health equity in my work?
- ✓ Do I incorporate health equity in my daily activities and practice?
- ✓ How can my understanding of diversity and bias shape my role and activities on the team and with my patients?
- ✓ How robust is our stakeholder and community engagement in shaping my/our work?



# Reasons and Benefits of a Health Equity Lens



- Changing demographics in the US
- Significantly improves patient care
- Enhances patient-provider communication
- Addresses some key elements of trust
- Highlights our own biases and strategies to address
- Innovation and creativity is significantly enhanced
- Values of the organization becomes what patients v



— Implicit Bias Association

<https://implicit.harvard.edu/implicit/takeatest.html>



Thank you!

Questions and Comments