BARRIERS IN HEALTHCARE

Addressing social determinants of Health

Susan DeVuyst-Miller, PharmD
Clinical Pharmacist

1

- I have no relevant financial relationships to disclose.

2

Objectives

- Identify social determinants that impact health
- Explain the importance of addressing social determinants of health
- Given a patient scenario, recognize social determinants of health and their impact on the patient

3

R 338.7004 Implicit Bias Training Standards

- 1 hour of training for each year of the applicant's license cycle
- Must be related to reducing barriers and disparities in access to and delivery of health care services
- Must include the administration of pre- and post-assessments
- Acceptable sponsors include accredited colleges and universities

Licensing and Regulatory Affairs [LARA]. (2021). Public Health Code – General Rules: R 338.7004.

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Biases

Explicit	**Implicit**
• Attitudes, beliefs, and stereotypes that an individual is **aware** of, can control, and may selectively express • Individuals may choose to express such biases • *Conscious* mind	• A learned assumption, belief, or attitude towards an identity, individual that one possess **without awareness** • May be a direct contrast to one's stated believes • *Unconscious* mind

https://rise.articulate.com/share/ym4rPTFghzJCcW0qKyeAvsLRrNhToAVa#/lessons/poMMEk9os4nP_jZrKiCiAGXIfAPb_UkO

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- Leading cause of death: females by race

By Race and Hispanic origin[1], Female, All ages

	Race[1] and Hispanic Origin[3]						
Rank[2]	Non-Hispanic White	Non-Hispanic Black	Non-Hispanic Asian	Non-Hispanic American Indian or Alaskan Native	Non-Hispanic Native Hawaiian or Pacific Islander	Hispanic	All Races and Origins
1)	Heart Disease 21.9%	Heart Disease 23.0%	Cancer 25.4%	Cancer 17.9%	Cancer 25.5%	Cancer 22.0%	Heart Disease 21.8%
2)	Cancer 20.2%	Cancer 21.2%	Heart Disease 19.5%	Heart Disease 17.1%	Heart Disease 20.5%	Heart Disease 19.3%	Cancer 20.5%
3)	Chronic Lower Respiratory Disease 6.9%	Stroke 6.5%	Stroke 8.5%	Unintentional Injuries 8.2%	Stroke 7.2%	Stroke 6.5%	Stroke 6.2%
4)	Alzheimer's Disease 6.5%	Diabetes 4.5%	Alzheimer's Disease 5.6%	Chronic Liver Disease & Cirrhosis 6.2%	Diabetes 6.8%	Alzheimer's Disease 5.9%	Chronic Lower Respiratory Disease[4] 6.1%
5)	Stroke 6.0%	Alzheimer's Disease 3.9%	Diabetes 3.9%	Diabetes 5.6%	Unintentional Injuries 4.1%	Unintentional Injuries 4.9%	Alzheimer's Disease[4] 6.1%

https://www.cdc.gov/women/lcod/2018/byrace-hispanic/index.htm

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Objectives and Data
Tools for Action
Priority Areas
About
Custom List (0)
Healthy People 2030
Search
Healthy People 2030
Building a healthier future for all
https://health.gov/healthypeople
https://health.gov/our-work/national-health-initiatives/healthy-people/about-healthy-people/history-healthy-people

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Vision
A society in which all people can achieve their full potential for health and well-being across the lifespan.
Mission
To promote, strengthen, and evaluate the nation's efforts to improve the health and well-being of all people.
https://health.gov/healthypeople
https://health.gov/our-work/national-health-initiatives/healthy-people/about-healthy-people/history-healthy-people

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Foundational Principles
The following foundational principles guide decisions about Healthy People 2030:
The health and well-being of all people and communities is essential to a thriving, equitable society.
Promoting health and well-being and preventing disease are linked efforts that encompass physical, mental, and social health dimensions.
Investing to achieve the full potential for health and well-being for all provides valuable benefits to society.
Achieving health and well-being requires eliminating health disparities, achieving health equity, and attaining health literacy.
Healthy physical, social, and economic environments strengthen the potential to achieve health and well-being.
Promoting and achieving health and well-being nationwide is a shared responsibility that is distributed across the national, state, tribal, and community levels, including the public, private, and not-for-profit sectors.
Working to attain the full potential for health and well-being of the population is a component of decision-making and policy formulation across all sectors.
https://health.gov/healthypeople
https://health.gov/our-work/national-health-initiatives/healthy-people/about-healthy-people/history-healthy-people

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Overarching Goals

Achieving these broad and ambitious goals requires setting, working toward, and achieving a wide variety of much more specific goals. Healthy People 2030's overarching goals are to:

- Attain healthy, thriving lives and well-being free of preventable disease, disability, injury, and premature death.
- Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
- Create social, physical, and economic environments that promote attaining the full potential for health and well-being for all.
- Promote healthy development, healthy behaviors, and well-being across all life stages.
- Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.

https://health.gov/healthypeople
https://health.gov/our-work/national-health-initiatives/healthy-people/about-healthy-people/history-healthy-people

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Plan of Action

It's important to provide information and tools to help communities, states, and organizations use Healthy People. The Healthy People 2030 plan of action is to:

- Set national goals and measurable objectives to guide evidence-based policies, programs, and other actions to improve health and well-being.
- Provide accurate, timely, and accessible data that can drive targeted actions to address regions and populations that have poor health or are at high risk for poor health.
- Foster impact through public and private efforts to improve health and well-being for people of all ages and the communities in which they live.
- Provide tools for the public, programs, policymakers, and others to evaluate progress toward improving health and well-being.
- Share and support the implementation of evidence-based programs and policies that are replicable, scalable, and sustainable.
- Report biennially on progress throughout the decade from 2020 to 2030.
- Stimulate research and innovation toward meeting Healthy People 2030 goals and highlight critical research, data, and evaluation needs.
- Facilitate the development and availability of affordable means of health promotion, disease prevention, and treatment.

https://health.gov/healthypeople
https://health.gov/our-work/national-health-initiatives/healthy-people/about-healthy-people/history-healthy-people

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Healthy People 2030 uses a place-based framework that outlines five key areas of SDOH:

Healthcare Access and Quality
The connection between people's access to and understanding of health services and their own health. This domain includes key issues such as access to healthcare, access to primary care, health insurance coverage, and health literacy.

Education Access and Quality
The connection of education to health and wellbeing. This domain includes key issues such as graduating from high school, enrollment in higher education, educational attainment in general, language and literacy, and early childhood education and development.

Social and Community Context
The connection between characteristics of the contexts within which people live, learn, work, and play, and their health and wellbeing. This includes topics like cohesion within a community, civic participation, discrimination, conditions in the workplace, and incarceration.

5 Key areas of Healthy People 2030

Economic Stability
The connection between the financial resources people have – income, cost of living, and socioeconomic status – and their health. This area includes key issues such as poverty, employment, food security, and housing stability.

Neighborhood and Built Environment
The connection between where a person lives – housing, neighborhood, and environment – and their health and wellbeing. This includes topics like quality of housing, access to transportation, availability of healthy foods, air and water quality, and neighborhood crime and violence.

https://www.cdc.gov/socialdeterminants/about.html

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https://health.gov/healthypeople/priority-areas/social-determinants-health

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Characteristic

Table A-1.

People in Poverty by Selected Characteristics: 2020 and 2021

(Populations in thousands. Margins of error in thousands or percentage points as appropriate. Population as of March of the following year. Information on confidentiality protection, sampling error, nonsampling error, and definitions is available at <https://www2.census.gov/programs-surveys/cps/techdocs/cpsmar22.pdf>)

Characteristic	2020[1]					2021					Change in poverty (2021 less 2020)	
		Below poverty					Below poverty					
	Total	Number	Margin of error[2] (±)	Percent	Margin of error[2] (±)	Total	Number	Margin of error[2] (±)	Percent	Margin of error[2] (±)	Number	Percent
PEOPLE												
Total	327,570	37,548	899	11.5	0.3	328,191	37,933	908	11.6	0.3	385	0.1
Race[3] and Hispanic Origin												
White	249,083	25,183	671	10.1	0.3	248,909	24,919	650	10.0	0.3	-264	-0.1
White, not Hispanic	195,078	16,038	518	8.2	0.3	194,309	15,805	528	8.1	0.3	-233	-0.1
Black	43,694	8,556	420	19.6	1.0	43,976	8,583	476	19.5	1.1	27	-0.1
Asian	20,352	1,645	176	8.1	0.9	20,676	1,922	183	9.3	0.9	*277	*1.2
American Indian and Alaska Native	3,950	791	140	20.0	2.8	4,109	998	161	24.3	3.2	*206	4.2
Two or More Races	9,220	1,209	142	13.1	1.4	9,166	1,298	176	14.2	1.8	89	1.0
Hispanic (any race)	61,769	10,520	480	17.0	0.8	62,482	10,690	469	17.1	0.8	170	0.1
Sex												
Male	161,565	16,621	473	10.3	0.3	161,793	17,019	478	10.5	0.3	398	0.2
Female	166,006	20,926	538	12.6	0.3	166,398	20,914	542	12.6	0.3	-13	Z
Age												
Under 18 years	73,541	11,789	418	16.0	0.6	72,936	11,149	444	15.3	0.6	*-640	*-0.7
18 to 64 years	199,753	20,907	537	10.5	0.3	199,062	20,982	516	10.5	0.3	75	0.1
65 years and older	54,276	4,852	236	8.9	0.4	56,193	5,802	236	10.3	0.4	*950	*1.4
Nativity												
Native-born	282,408	31,485	792	11.1	0.3	281,383	31,083	820	11.0	0.3	-402	-0.1
Foreign-born	45,162	6,063	318	13.4	0.7	46,808	6,850	344	14.6	0.7	*786	*1.2
Naturalized citizen	22,800	2,087	154	9.2	0.6	22,874	2,428	194	10.6	0.8	*342	*1.5
Not a citizen	22,362	3,977	264	17.8	1.1	23,934	4,422	288	18.5	1.1	*445	0.7

Table 1

Economic Stability

https://www.census.gov/library/publications/2022/demo/p60-277.html

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Federal Poverty Level (FPL)

Family size	2022 income numbers	2023 income numbers
For individuals	$13,590	$14,580
For a family of 2	$18,310	$19,720
For a family of 3	$23,030	$24,860
For a family of 4	$27,750	$30,000
For a family of 5	$32,470	$35,140
For a family of 6	$37,190	$40,280
For a family of 7	$41,910	$45,420
For a family of 8	$46,630	$50,560
For a family of 9+	Add $4,720 for each extra person	Add $5,140 for each extra person

Note: Federal Poverty Level amounts are higher in Alaska and Hawaii. Get all HHS poverty guidelines for 2023.

https://www.healthcare.gov/glossary/federal-poverty-level-fpl/

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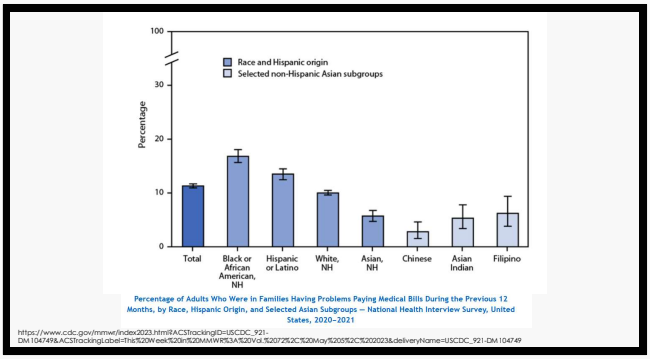

Percentage of Adults Who Were in Families Having Problems Paying Medical Bills During the Previous 12 Months, by Race, Hispanic Origin, and Selected Asian Subgroups — National Health Interview Survey, United States, 2020–2021

https://www.cdc.gov/mmwr/index2023.html#ACSTrackingID=USCDC_921-DM104749&ACSTrackingLabel=This%20Week%20in%20MMWR%3A%20Vol.%2072%2C%20May%205%2C%202023&deliveryName=USCDC_921-DM104749

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Education Access and Quality

- Higher levels of education versus lower levels of education
  - Live longer
  - Healthier
- Social discrimination
  - Struggle with math & reading
  - Less likely to graduate high school
  - Less likely to go to college
  - …less likely to have the good paying job
  - …more likely to have health problems

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Healthcare Access and Quality

- 2022: 8% do not have health insurance
  - Less likely to have a primary care provider
  - May not be able to afford medications
  - Less likely to get preventative care
  - Less likely to get health screenings
- Remote/rural
- Underinsured
- High-deductible

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Neighborhood and Built Environment

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Zip Code & Your Health

Graham GN. Why Your ZIP Code Matters More Than Your Genetic Code: Promoting Healthy Outcomes from Mother to Child. Breastfeed Med. 2016 Oct;11:396-7. doi: 10.1089/bfm.2016.0113. Epub 2016 Aug 11. PMID: 27513279.
https://www.bluezones.com/2020/02/zip-code-effect-your-neighborhood-determines-your-lifespan/#

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Social and Community Context

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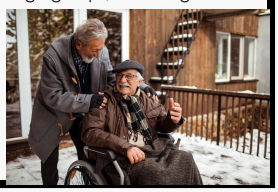
Health Disparities

- …preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups, and communities. Health disparities exist in all age groups, including older adults. (www.cdc.gov)
- Mortality
- Life expectancy
- Burden of disease
- Mental health
- Uninsured/underinsured
- Lack of access to care



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Microaggressions

https://dental.touro.edu/news--events/events/list/microaggressions.php

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Intent ≠ Impact

Zheng, L.(2023) *DEI Deconstructed Your NoBnonsense Guide to Doing The Work and Doing It Right*. Berrett-Koehler Publisers.

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ADDRESSING SOCIAL DETERMINANTS OF HEALTH IN OUR COMMUNITY

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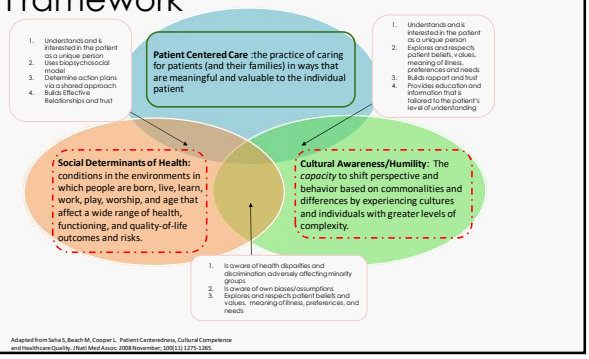
Framework



Adapted from Saha S, Beach M, Cooper L. Patient Centeredness, Cultural Competence and Healthcare Quality. J Natl Med Assoc. 2008 November; 100(11):1275-1285.

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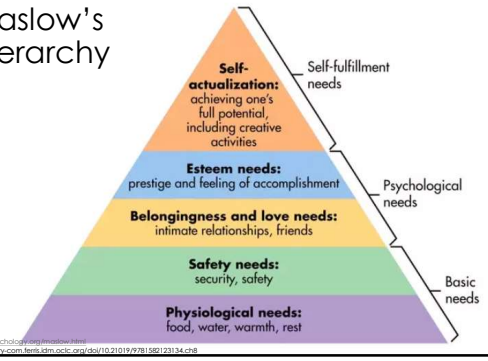
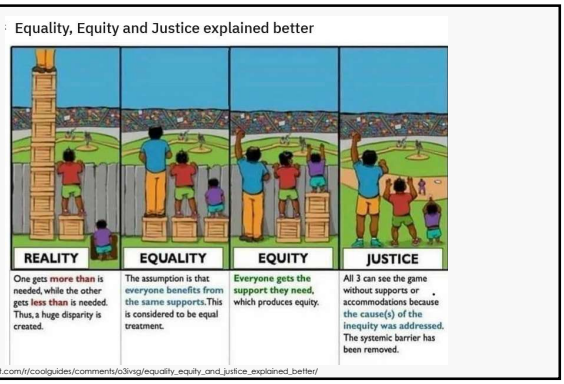
Maslow's Hierarchy



https://www.simplypsychology.org/maslow.html
https://pharmacylibrary-com.ferris.idm.oclc.org/doi/10.21019/9781582123134.ch8

28



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What to do…

- Cultural awareness
  - Implicit bias trainings
- Partnerships
- Exposure
- Communication
  - Medically trained interpreters
- Address patient specific concerns - social determinants of health
- Ask relevant questions – patient/person centered

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Linguistic competency

- Capacity of an organization and its personnel to communicate effectively and convey information in a manner that is easily understood by diverse audiences.
  - Limited English proficiency
  - Low literacy
  - Hearing or visual limitations
- Reduce medication related errors

Ellingrod VL, eds. *DiPiro: Pharmacotherapy A Pathophysiologic Approach, 12e*. McGraw Hill; 2021. Accessed October 1, 2022. https://accesspharmacy-mhmedical-

31

Community Awareness

- History
- Context
- Geography
- Culture

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Population Health

- The health status and outcomes within a group of people rather than considering the health of one person
- "Brings significant health concerns into focus and address ways that resources can be allocated to overcome the problems that drive poor health conditions in the population."
- "An opportunity for health care systems, agencies and organizations to work together in order to improve the health outcomes of the communities they serve."

www.cdc.gov

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Addressing SDoH & Impact on patients

- Improve patient care
  - Consistent with their beliefs
- Access to resources
  - Unique to their community
  - Culturally appropriate
- Improve patient outcomes
- Healthier communities

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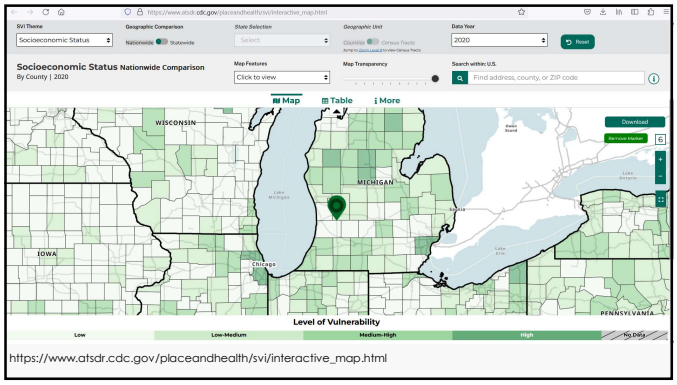
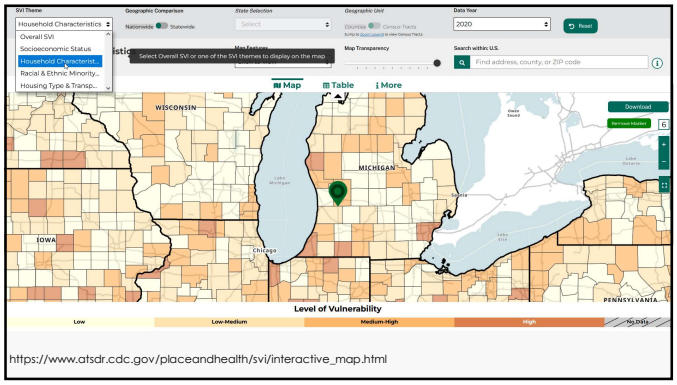


https://www.atsdr.cdc.gov/placeandhealth/svi/interactive_map.html

35



https://www.atsdr.cdc.gov/placeandhealth/svi/interactive_map.html

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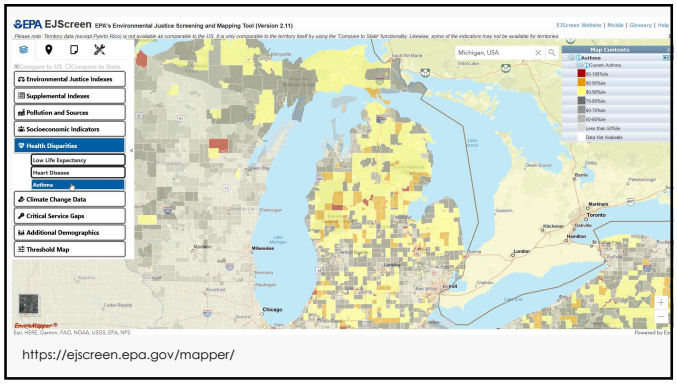
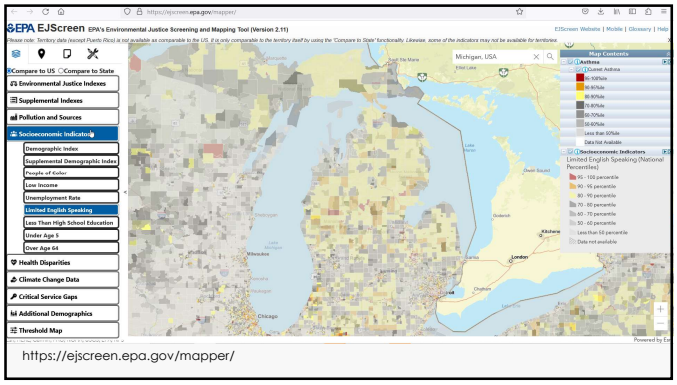


https://ejscreen.epa.gov/mapper/

37



https://ejscreen.epa.gov/mapper/

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Learning

Lifelong

- Formal
- Informal
- Community engagement
- Collaborative

Transformational

- Search, analyze and synthesize information →decision making
- Collaborate and partner with others in a manner that is effective
- Value the role of others

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Addressing Implicit Biases

Stereotype replacement	• Replace stereotypic thoughts or responses with responses not based on stereotypes
Counter-stereotypic imaging	• Imagine in detail a person who represents the opposite of your stereotype for that group
Individuation	• Obtain specific information about group members to encourage evaluation based on personal, rather than group-based, attributes
Perspective taking	• Taking the perspective of the stereotyped group to increase psychological closeness
Increasing opportunities for contact	• Seek opportunities to engage in positive interactions with stigmatized group members

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Pharmacist role

- Be more culturally (self)aware
  - Interrogate reactions and/or expectations
  - Identify & address their personal bias(es)

["Why do I feel this way or view this patient this way?"]

- Diffuse stereotypes/assumptions
- Consider social determinants of health

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CASES

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Sid - 60-year-old African American Male

Diagnoses
- Diabetes
- Hypertension
- Mixed hyperlipidemia
- Benign prostatic hyperplasia
- Osteoporosis
- Groin pain
- Neuropathic pain

Medications
- Vitamin D3
- Tadalafil
- Atorvastatin
- Omeprazole
- Lisinopril
- Tamsulosin
- Mirtazapine
- Lidocaine
- VGO
- Insulin lispro
- Insulin glargine

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- Pause and consider
  - Some of your assumptions
  - Thoughts regarding this patient

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Sid – more to his life

- **Diagnoses**
  - Diabetes
  - Hypertension
  - Mixed hyperlipidemia
  - Benign prostatic hyperplasia
  - Osteoporosis
  - Groin pain
  - Neuropathic pain
  - Ascites due to **alcohol** cirrhosis
  - **Depression**
  - **Needle phobia**

- **Medications**
  - Vitamin D3
  - Tadalafil
  - Atorvastatin
  - Omeprazole
  - Lisinopril
  - Tamsulosin
  - Mirtazapine
  - Lidocaine
  - VGO
  - Insulin lispro
  - Insulin glargine

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Sid's life

- Social determinants
  - Education
  - Financial
  - Employment
  - Income
  - Healthcare
  - Transportation
  - Housing
  - Social support
  - Culture
  - Mental Health
  - Community engagement
  - Other context

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Analogous patient . . . *Or is it?* Marcus – 60-year-old African American Male

Diagnoses

- Diabetes
- Hypertension
- Mixed hyperlipidemia
- Benign prostatic hyperplasia
- Osteoporosis
- Groin pain
- Neuropathic pain

Medications

- Vitamin D3
- Tadalafil
- Atorvastatin
- Omeprazole
- Lisinopril
- Tamsulosin
- Mirtazapine
- Lidocaine
- VGO
- Insulin lispro
- Insulin glargine

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Sid and Marcus

- What assumptions did you make based on the disease state and medication?

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Instruction for Attestation of Completion

- You **must self-attest and/or possess a certificate** to document completion of training. Fill-in-the-blank attestation will be available upon completion of the post-assessment.
  - Your name
  - Name of program
  - Sponsor of program
  - Date of program

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Self Attestation example:

Thank you for completing the post-presentation survey. This completes your requirements for the Certificate of Completion. Your self attestation is proof of completion.

I _____ [licensee] attest that on _____ [date, month, year of training program], I completed 2 hours of Implicit Bias Training [title of program] as required by the Board of Pharmacy Rule R338.7004. The training was sponsored by the _____ [program sponsor's name] and presented by Susan DeVuyst-Miller, PharmD, of Ferris State University College of Pharmacy.

Keep this for your records in the event of Michigan Board of Pharmacy or Michigan Licensing and Regulatory Affairs audit. Recall licensees are expected to retain documentation of meeting the requirements of Implicit Bias Training for a period of 6 years from the date of applying for licensure, registration, or renewal.

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