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Disparities, Diversity, & Inclusion in Post Acute Long-Term Care

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OBJECTIVES & AGENDA

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OBJECTIVES

Review the landscape of healthcare disparities among PALTC settings

Discuss ways that the Chief Medical Director can improve inclusion in the workplace

Identify resources to support inclusion and diversity

AGENDA

- **What Do You Mean?**
  - Definitions: Diversity, Equality vs. Equity, Inclusion, & Health Disparities
- **How Did We Get Here?**
  - Root Causes and Historical Background
- **What's the 411?**
  - Statistics – Residents, Patients, Clients
- **What's Going On?**
  - A look at disparity in various settings
- **Whose Role Is It Anyway?**
  - Inclusion in the workplace– Who is responsible for making the changes?
- **How Do We Fix IT ?**
  - Resources to advance DEI in PALTC settings for:
    - Patient and family experience/addressing the disparities
    - Workforce inclusion
    - Recommended Reading

WHAT DO YOU MEAN? – DEFINITIONS

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DIVERSITY

A wide range of attributes within an individual, group or community. The various dimensions of diversity include ethnicity, race, gender, sexual orientation, ancestry, age, socio-economic status, gender identity, gender expression, physical abilities, political beliefs, religious beliefs, and other ideologies.

Understanding and respecting these differences among each other can foster a mutually supportive environment.

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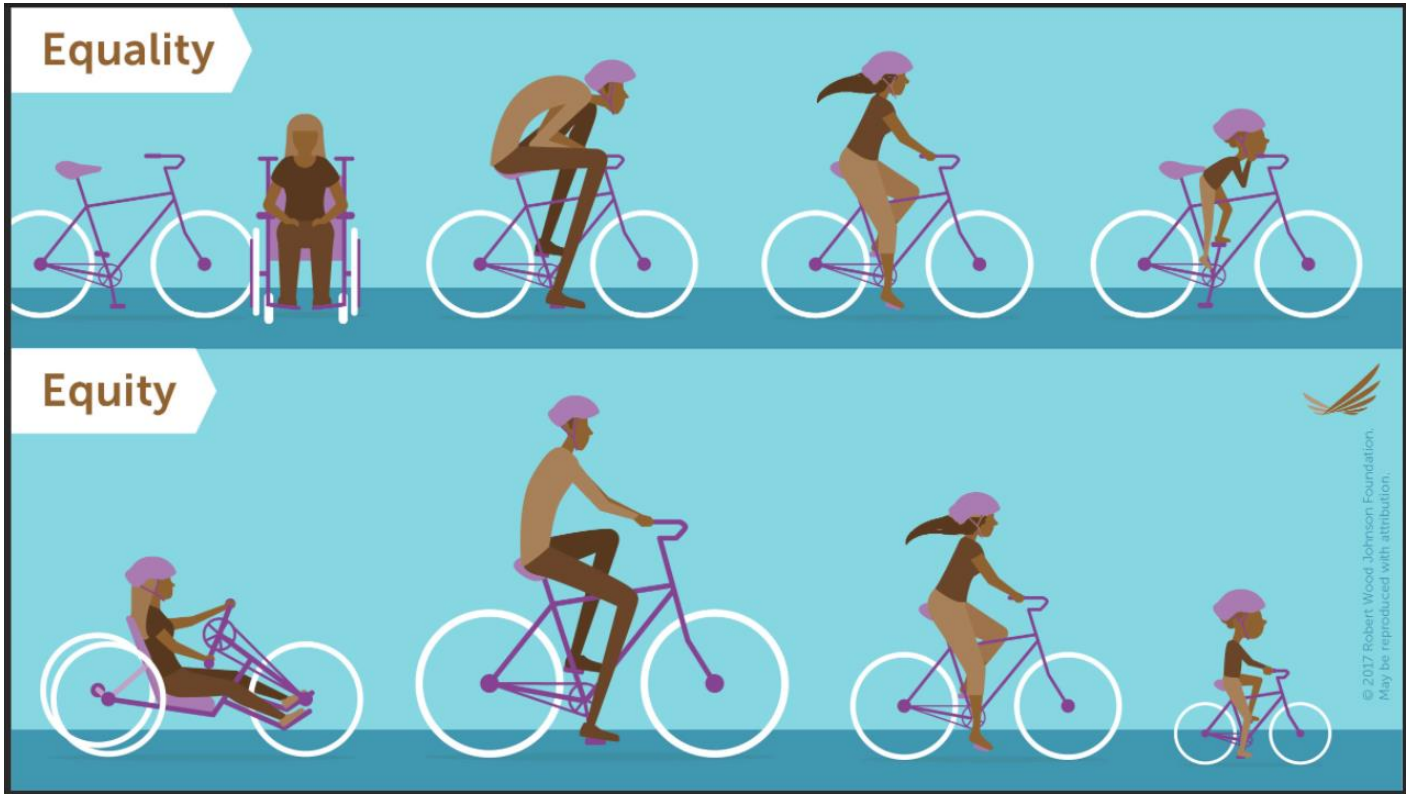
Source: https://clri-ltc.ca/files/2020/06/Diversity-Toolkit-Working-File_Accessible_June11.pdf

EQUALITY VS. EQUITY



Source: Robert Wood Johnson Foundation

INCLUSION

Inclusion leverages diversity to create a fair, equitable, healthy, and high-performing organization or community where all individuals are respected, feel engaged and motivated, and their contributions toward meeting organizational and community and societal goals are valued.

Source: https://researchguides.austincc.edu/EquityDiversityInclusion/Inclusion

HEALTH DISPARITIES

The CDC defines a health disparity as:

"Health disparities are ***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."

Healthy People 2020 defines a health disparity as:

"A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage".

Source: https://www.cdc.gov/aging/disparities/index.htm

Source: https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

HEALTH DISPARITIES

Factors that contribute to health disparities:

- Race or ethnicity group
- Religion
- Socioeconomic status
- Gender
- Age
- Mental health
- Cognitive, sensory, or physical disability
- Sexual orientation or gender identity
- Geographic location (rural vs. urban)

Source: https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

HEALTH DISPARITIES

- Some disparities were getting smaller from 2000 through 2016–2018, but disparities persist some even worsened, especially for poor and uninsured populations in all priority areas.
- Racial and ethnic disparities vary by group:
  - Blacks and American Indians and Alaska Natives received worse care than Whites for about 40% of quality measures.
  - Hispanics received worse care than Whites for more than one-third of quality measures.
  - Asians received worse care than Whites for nearly 30% of quality measures but better care for nearly one-third of quality measures.
  - Native Hawaiians/Pacific Islanders received worse care than Whites for one-third of quality measures.

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Source: 2019 National Healthcare Quality and Disparities Report. Executive Summary.

HEALTH DISPARITIES

Disparities vary by residence location:

- For nearly a quarter (24 of 102) of quality measures, residents of large central metropolitan areas received worse care than residents of large fringe metropolitan areas.
- For one-third of quality measures, residents of micropolitan and noncore areas received worse care than residents of large fringe metropolitan areas.
- For a little less than 20% of quality measures, medium and small metropolitan residents received worse care than residents of large fringe metropolitan areas.

Source: 2019 National Healthcare Quality and Disparities Report. Executive Summary.

HOW DID WE GET HERE? – ROOT CAUSES

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ROOT CAUSES

Residential segregation

Structural barriers
- Racism
- Implicit Bias
- Racial restrictive covenants
- Mortgage loans redlining
- Unfavorable property appraisals

Inequitable delivery of education

Economic and Employment opportunities

Disproportionate availability and delivery of health care dependent on zip code

Geography

Source: Dawes, Daniel E. The Political Determinants of Health

HISTORY & BACKGROUND

- Structural Racism impacted and still impacts employment and housing and a key contributor to income and wealth disparities.
    - Income disparities based on race – greater and rapidly growing gap between the median net worth of African American and Latino families and that of white families.
    - More people of color with likely less resources to afford to pay for their care = fewer options on where to receive long term care.
- Lack of trust in the healthcare settings and government funded programs
    - Tuskegee (1932-1972)
    - Gynecological "research" (19th Century)

Source: Dawes, Daniel E. The Political Determinants of Health

Source: https://doi.org/10.1377/hlthaff.2018.05233

Source: https://www.chausa.org/docs/default-source/health-progress/health-equity---reducing-disparities-in-eldercare.pdf?sfvrsn=0

WHAT'S THE 411? – STATISTICS

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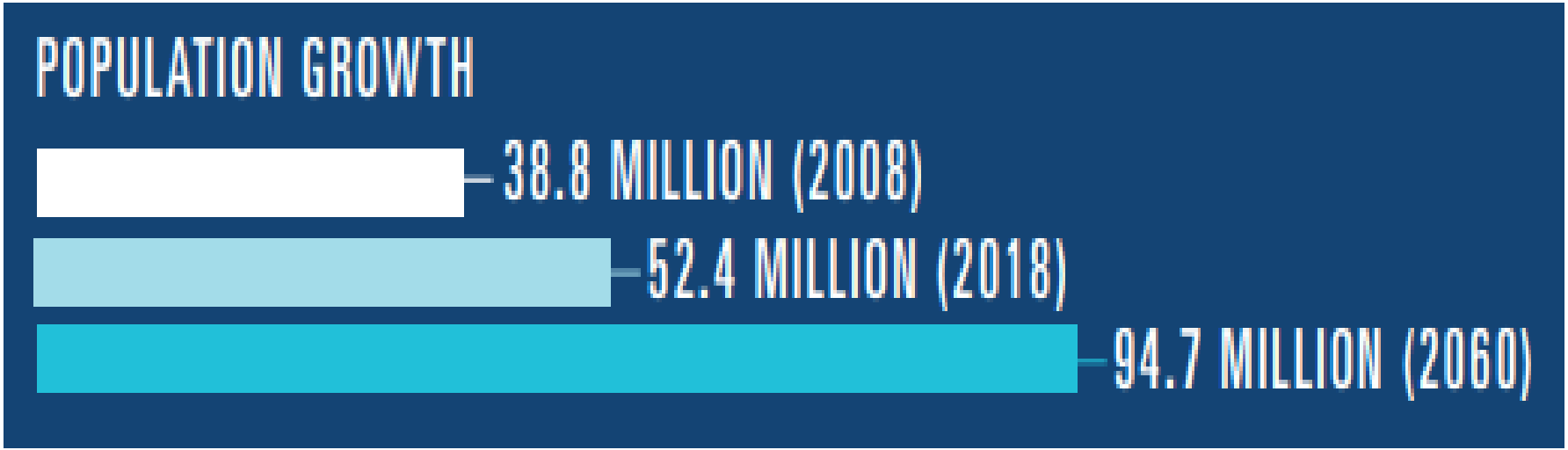
STATISTICS –RESIDENTS, PATIENTS, CLIENTS…



Source: 2019 Profile of Older Americans. Administration on Aging

STATISTICS –RESIDENTS, PATIENTS, CLIENTS…

- In 2018, 23% of persons age 65 and older were members of racial or ethnic minority populations:
  - 9% were African Americans (not Hispanic)
  - 5% were Asian (not Hispanic)
  - 0.5% were American Indian and Alaska Native (not Hispanic)
  - 0.1% were Native Hawaiian/Pacific Islander (not Hispanic)
  - 0.8% of persons 65 and older identified themselves as being of two or more races.
  - Persons of Hispanic origin (who may be of any race) represented 8% of the older population.

- In 2018, nearly 1 in 10 older adults lived below the poverty level.

Source: 2019 Profile of Older Americans. Administration on Aging

STATISTICS –RESIDENTS, PATIENTS, CLIENTS…

- ~ 70% of people currently turning 65 will require long-term care
- 18% of all seniors will require more than one year in a nursing facility.
  - Only 3% of senior citizens live in nursing homes
- Annual spending on long-term care has reached nearly $275 billion.
  - 47% is Medicaid
  - 23% is Medicare
  - 23% by Families out-of-pocket expenses,
  - less than 4% by Veterans/State programs
  - less than 3% is private long-term care insurance
- $450 billion annually, the value of uncompensated care provided by family or friend
- By the end of the decade, 24 million Americans will need long-term care, nearly double the current need, but there won't be enough caregivers to meet the demand

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Source: https://www.phca.org/for-consumers/research-data/long-term-and-post-acute-care-trends-and-statistics

WHAT'S GOING ON? – DISPARITIES IN PALTC SETTINGS

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CCRC/LPC AND ALF

- White elders have more access to alternatives to nursing home care than do minority seniors, highlighting another disparity in access to care

- By 2029, 7.5 million Americans will not be able to afford assisted living
  - Of the 7.5 million, 83% of African American households will have insufficient income, compared to 53% of the White population

- Assisted living, continuing care retirement communities and private-home health care are expensive and inaccessible to seniors with lower incomes and fewer assets

Source: https://publicintegrity.org/health/nursing-homes-serving-minorities-offering-less-care-than-those-housing-whites/

Skilled Nursing

- Racial and ethnic minorities are more likely to live in facilities with fewer resources
- Lower quality indicators and low nursing staff ratios
- Staffing levels in majority-white nursing homes are 34% higher than those in majority-black homes, and 60% higher than those in majority-Latino nursing homes
- 20 minutes per day registered nursing care for African Americans and 10 minutes per day for Latino homes.

Source: https://publicintegrity.org/health/nursing-homes-serving-minorities-offering-less-care-than-those-housing-whites/

Home Health

- Only 54 % of Medicare patients referred to home health care services following a hospitalization received home health care visits
- Black and Hispanic Medicare beneficiaries received home health at lower rates than White patients by 7.3% and 9.2%
- Patients residing in disadvantaged neighborhoods – those in ZIP codes with high poverty and unemployment rates – received lower rates of home health care services by approximately 5 percentage points.
- Home safety considerations – for both patient and staff
- Minority patients had more adverse events, less improvement in functional outcomes, and worse patient experiences when compared with majority patients.

Source: doi: 10.1001/jamanetworkopen.2020.15470
Source: https://www.ncbi.nlm.nih.gov/books/NBK43619/
Source: https://pubmed.ncbi.nlm.nih.gov/28826334/

Hospice & Palliative Care

- Utilization is lower among racial and ethnic minorities
  - 82% – Caucasian/White
  - 8.2% – African American
  - 6.7% – Hispanic
  - 1.8% – Asian/Pacific Islander
  - 0.5% – Other
  - 0.4% – Native American
  - 0.4% – Unknown
- African-Americans and Hispanics are less likely to be assessed and treated for pain, and they find it harder to fill prescriptions.
  - Pharmacies in poorer or minority neighborhoods are less likely to carry opioids.

Source: www.nhpco.org/factsfigures
Source: https://www.chausa.org/docs/default-source/health-progress/health-equity---reducing-disparities-in-eldercare.pdf?sfvrsn=0

ADDRESSING THE DISPARITIES

- Develop and Strengthen Community Partnerships
- Access to and Active Participation in Organizations
- Raising Public Awareness through Increased Education and Training
- Visibly Inclusive Long-term Care Substantiated by Inclusive Policy

WHOSE ROLE IS IT? – INCLUSION IN THE WORKPLACE

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FACTORS IMPACTING INCLUSION IN THE WORKPLACE

- Presence of discrimination
- The silent witness (people who witness discrimination)
- The interplay of hierarchy, recognition and civility
- The effectiveness of organizational leadership and mentors
- Support for work-life balance
- Feeling excluded from inclusive efforts

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Source: Perceptions of Factors Associated With Inclusive Work and Learning Environments in Health Care Organizations: A Qualitative Narrative Analysis

WHOSE ROLE IS IT?

- Board of Directors
- CEO
- C-Suite and Senior Leadership
- Human Resources
- Compliance
- Diversity Officer/Leader
- Administrative Staff
- Support Staff
- Rehab Department
- Clinical Staff
- Medical Services

IT'S EVERYONE'S JOB!!

THE 4 PRIMARY ROLES OF THE MEDICAL DIRECTOR

QUALITY CARE

PHYSICIAN LEADERSHIP

PATIENT CARE – CLINICAL LEADERSHIP

EDUCATION, INFORMATION, AND COMMUNICATION

Source: 2015-20-ltc-nanda.pdf (rimed.org)

WHY THE MEDICAL DIRECTOR?

Leadership sets the tone!

Work processes and company cultures are traditionally guided – and influenced – via a top-down approach.

Source: hbr.org/hbr-analytic-services

THE MEDICAL DIRECTOR SHOULD:

- Educate physicians and clinical staff about unconscious biases and garnering patient trust
- Physician engagement include transparency, alignment of goals, and physician empowerment
- Promote and ensure responsibility across all disciplines in terms of health equity
- Remove obstacles that interfere with patient care
- Lead the charge to confront public health crises
- Drive the ongoing training and education
- Implement an institutional culture based on trust, equity, professionalism, and respect.

Source: https://www.healthleadersmedia.com/clinical-care/chief-medical-officers-role-addressing-health-equity

WHAT'S YOUR ROLE??

What can YOU do in your role to address and promote inclusion in the workplace??

CREATING WORKPLACE INCLUSION

Create a welcome environment

Build a diverse community

Create spaces for difficult conversations

Support and sustain an open environment

HOW DO WE FIX IT? – RESOURCES AND RECOMMENDATIONS

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RECOMMENDATIONS TO SUPPORT DEI

ACKNOWLEDGE our own biases and knowledge gaps is a powerful place to start

AVOID ASSUMPTIONS

AMPLIFY STAFF

ADVOCATE

Source: https://www.physiciansweekly.com/health-inequities-in-hospice-end-of-life-care

ACKNOWLEDGEMENT & AVOIDING ASSUMPTIONS

Data Collection

- Internal staff assessment – initial and ongoing

Education and training

- Consult with a DEI expert
- Cultural and linguistic competence

Staff and patient/resident recruitment and retention

- Use inclusive language
- Representation matters – check your marketing and recruitment materials

AMPLIFY & ADVOCATE

Recognition of religious and cultural holidays and observances

- Black History Month, Hispanic Heritage Month, Rosh Hashana, Diwali, Mental Health Awareness and more!

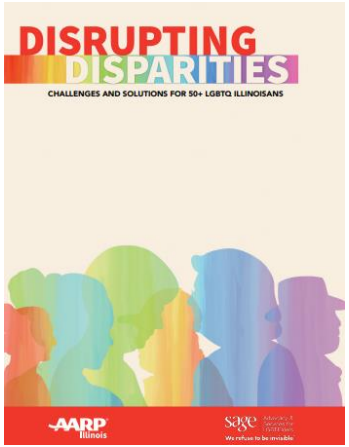
Create DEI councils and or Employee / Patient resource (affinity) groups

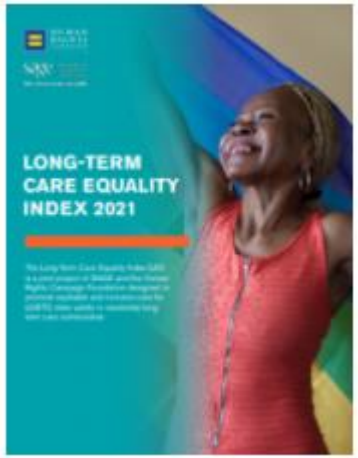
- Helps build and foster more inclusive workplace/community
- Addresses diversity and inclusion in a more holistic, community-based way

Creative Strategies

- Alternative Pricing and Options (creative housing strategies to make more accessible.
- Review and update policies, pay practices and presentation matters
- Connect with diverse community groups.

RESOURCES and TOOLS





https://clri-ltc.ca/resource/embracingdiversity/

https://www.sageusa.org/resource-posts/facts-on-lgbt-aging/

https://www.sageusa.org/wp-content/uploads/2021/10/disrupt-disparities-lgbtq-report-il-2021.pdf

https://www.sageusa.org/resource-posts/long-term-care-equality-index-2021/

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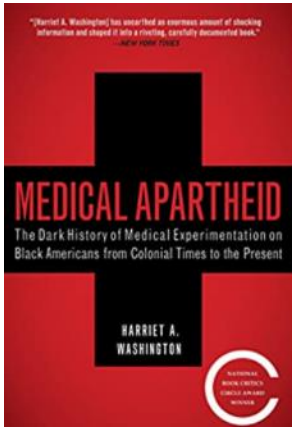
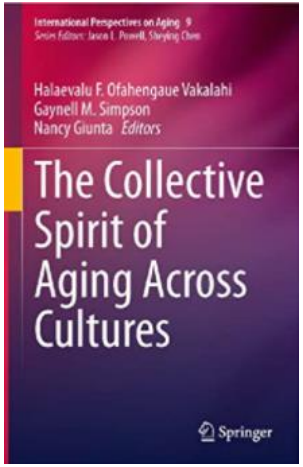
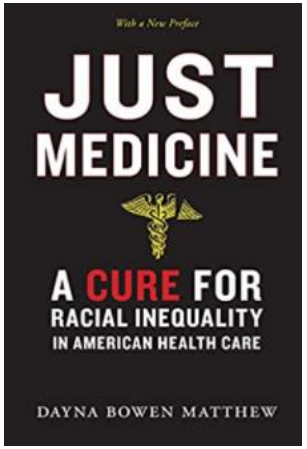
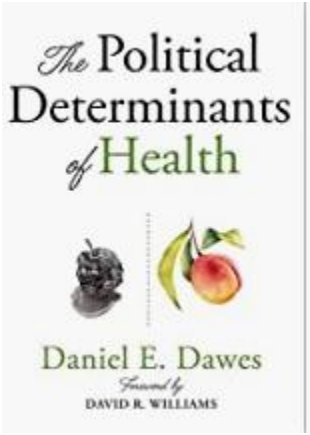
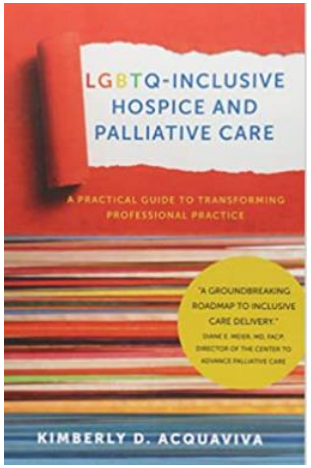
RECOMMENDED READING











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QUESTIONS??

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