

# **Nursing's Role in Achieving Health Equity**

### Lisa A. Cooper, M.D., M.P.H.

Bloomberg Distinguished Professor James F. Fries Professor of Medicine Director, Johns Hopkins Center for Health Equity, Director, Johns Hopkins Urban Health Institute @LisaCooperMD @Jhhealthequity



EQUITY FOR VULNERABLE POPULATIONS"

# **From Health Disparities to Health Equity**

### **Health Disparities:**

"...**preventable** differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations"<sup>1</sup>

### Health Equity:

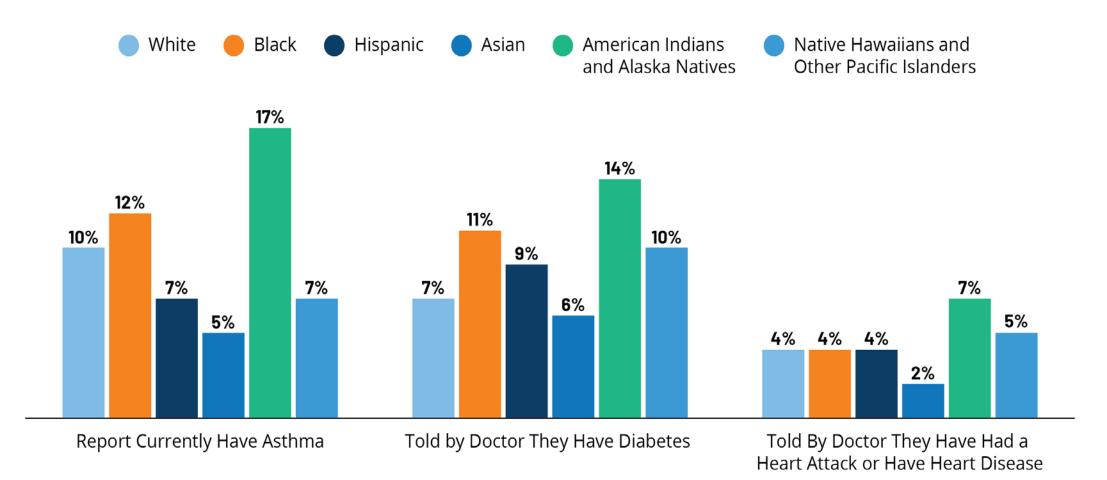
"When every person has the opportunity to 'attain his or her full health potential' and no one is 'disadvantaged from achieving this potential because of social position or other socially determined circumstances"<sup>2</sup>

1. Community Health and Program Services (CHAPS): Health Disparities Among Racial/Ethnic Populations. U.S. Department of Health and Human Services; 2008.

2. Whitehead M, Dahlgren G. Levelling Up (Part 1): A Discussion Paper on Concepts and Principles for Tackling Social Inequities in Health. World Health Organization. Available at http://www.euro.who.int/document/ e89383.pdf.



### Percent of Nonelderly Adults with Selected Health Conditions by Race/Ethnicity, 2018



https://www.kff.org/coronavirus-covid-19/issue-brief/communities-of-color-at-higher-risk-for-health-and-economic-challenges-due-to-covid-19/

# Vulnerable Populations and Groups with Health Disparities in U.S.

- People of Color
- Persons with Low Income
- Immigrants
- Women
- Children
- Older Adults
- Homeless or housing insecure
- Persons with chronic conditions

- LGBTQ
- Individuals with Special Needs
- Rural and Urban Residents
- Persons with Low Literacy and Numeracy
- Persons in correctional institutions
- Residents of nursing homes and assisted living facilities



#### Sources

- National Healthcare Quality and Disparities Report. Rockville, MD: Agency for Healthcare Research and Quality; September 2019. AHRQ Publication No.
- 2. Mechanic D, Tanner J. Health Affairs (Millwood). 2007 Sep-Oct;26(5):1220-30.



### Challenges Magnified for Vulnerable Populations During COVID-19 Outbreak





Lack of access to basic resources such as food, water, shelter, and transportation



Suboptimal housing conditions



Employment in essential jobs with limited protections



Lack of access to healthcare services



Mistrust of institutions due to discriminatory experiences



#### **COVID-19 CASES, HOSPITALIZATION, AND DEATH BY RACE/ETHNICITY**





<sup>1</sup> Data source: COVID-19 case-level data reported by state and territorial jurisdictions. Case-level data include about 80% of total reported cases. Numbers are unadjusted rate ratios.

<sup>2</sup> Data source: COVID-NET (https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html, accessed 08/06/20). Numbers are ratios of age-adjusted rates.

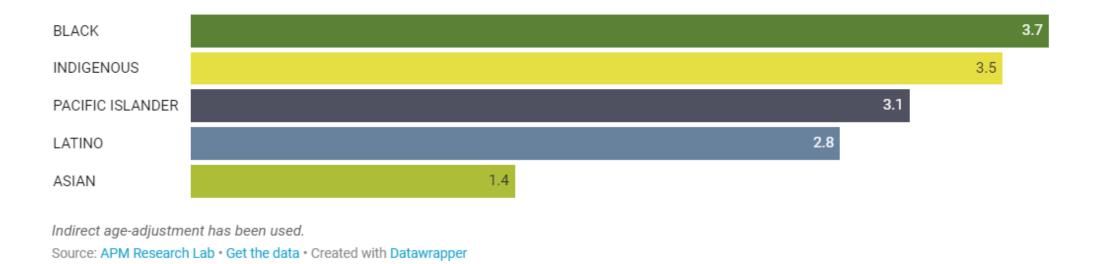
<sup>3</sup> Data source: NCHS Provisional Death Counts (https://www.cdc.gov/nchs/nvss/vsrr/COVID19/index.htm, accessed 08/06/20). Numbers are unadjusted rate ratios. cdc.gov/coronavirus

CS319360-A 08/08/2020

### **COVID-19 Deaths Per 100,000 People by Race and Ethnicity**

# Adjusted for age, other racial groups are this many times more likely to have died of COVID-19 than White Americans

Reflects mortality rates calculated through Aug. 4.



Source: https://www.apmresearchlab.org/covid/deaths-by-race



### A Game Plan to Help the Most Vulnerable

#### POLITICO THE AGENDA

#### OPINION | CORONAVIRUS

#### A Game Plan to Help the Most Vulnerable

It won't be enough to wear face masks and use Zoom. Here's what we really need to do.



Track data on COVID-19 cases by race, ethnicity, and geography

Communicate and

communities of color

build trust with

4

Protect essential and low wage workers

JOHNS HOPKINS

CENTER for HEALTH EQUITY



Provide social services to keep vulnerable groups safe

3

Enhance access to testing and health care Source: Cooper LA, Sharfstein JM. https://www.politico.com/news/agenda/ 2020/04/07/game-plan-to-help-thosemost-vulnerable-to-covid-19-171863





Purnell TS, Cooper LA, et al. Achieving Health Equity: Closing the Gaps in Health Care Disparities, Interventions, and Research. *Health Aff.* 2016 Aug 1; 35(8): 1410-5.

## **COVID-19 and Health Equity: A New Kind of "Herd Immunity"**

COVID-19 and Health Equity-A New Kind of "Herd Immunity" David R. Williams, PhD, MPH; Lisa A. Cooper, MD, MPH

Three articles recently published in JAMA provide insight into tings and vulnerable groups, is an important "treatment" for the large racial/ethnic differences associated with coronavi- racial disparities in health. rus disease 2019 (COVID-19) and highlight the need for, and

otential opportunity to, redouble efforts in the US to de- Beyond Medical Care

causes of death.

Health Care Access and Ouality Matter Owen and colleagues1 provide a poignant example of sys- were concentrated in 4 neighborhoods. temic inequities in health care. Compared with white individuals, African American individuals have higher rates of by place, and opportunities to be healthy vary markedly at the uninsurance and underinsurance. Segregation of health care neighborhood level. A clue to understanding the drivers of also contributes to racial disparities in health care with access these differences is the 2010 Census finding that the New York to primary care and especially specialty care physicians City area was the second most segregated metropolitan area more limited in communities of color, COVID-19 testing cen-in the US, behind Milwaukee and ahead of Chicago, Detroit ters are more likely to be in well-off suburbs of predomi- and Cleveland.7 An estimated 78% of African American resi nantly white residents than in low-income neighborhoods dents in New York City would have to relocate to have an even that are predominantly black. The advice to obtain testing distribution of black and white populations. The problem of through a primary care clinician limits access to testing for segregation is not residing among persons of the same race, people who lack one.

One way that racism adversely affects minorities is investment in marginalized communities. through the negative beliefs and stereotypes about race that are embedded in US culture. Studies from 2015 and 2017 preciated driver of inequality in the US. Although segregation reported that the majority of health care clinicians had has been illegal since the 1960s, it is perpetuated through an implicit biases against African American individuals and that interlocking set of individual actions, institutional practices, bias in the clinical encounter was associated with poorer and governmental policies. Reported recent declines in segpatient-clinician communication and quality of care.4.5 regation have not altered the residential concentration and iso-A recent report based on billing data for COVID-19 testing lation of most African American populations in urban spaces. from several states revealed that African American patients In addition, although most immigrant groups have experiwith symptoms such as cough and fever were less likely than enced residential segregation in the US, no immigrant group white individuals with the same symptoms to be given a has lived under the high levels of segregation that have ex test.<sup>6</sup> Health care workers are heroes because they care for isted for black people for more than a century. patients affected by this pandemic, but they are also human,

velop strategies that would However, medical care alone will not provide the needed enable society to slow and ul- "herd immunity" to racial/ethnic inequities in health. Owen timately eliminate the spread and colleagues1 indicate that the main contributor is the of inequities in health.<sup>1-3</sup> COVID-19 is a magnifying glass that long-term pathogenic effects of exposure to adverse living has highlighted the larger pandemic of racial/ethnic dispari-and working conditions. The analyses by Wadhera and ties in health. For more than 100 years research has docu- colleagues<sup>2</sup> provide further insight. The authors show that mented that African American and Native American individu-risks linked to COVID-19 varied markedly by borough of resi als have shorter life spans and more illness than white persons. dence in New York City. The Bronx had the lowest levels o Hispanic immigrants initially tend to have a relatively healthy income and education and the highest proportion of black profile but with increasing length of stay in the US, their health and Hispanic persons. Although the Bronx had the highest tends to decline. A black infant born in the US is more than rate of COVID-19 tests performed, it also had the highest rate twice as likely to die before his or her first birthday compared of COVID-19 hospitalizations and deaths. In contrast, Man with a white infant. In adulthood, black individuals have hattan, the predominantly white, most affluent borough o higher death rates than white persons for most of the leading New York City, had the lowest rates of hospitalizations and death related to COVID-19, although it had the highest population density. Similarly, the Viewpoint by Yancy<sup>3</sup> notes that the disproportionate death rates for black persons in Chicago

These data highlight that social inequities are patterned but the clustering of social disadvantage and systematic dis

Residential segregation by race/ethnicity is an underap

Segregation is a critical determinant of economic status orking under stressful conditions that increase the risk of which is a strong predictor of variations in health. In 2018, biased behavior. Improving access to care for all and ensuring for every dollar of household income that white workers high-quality care, with greater focus on underresourced set- earned, black workers earned 59 cents and Hispanic workers

> JAMA Published online May 11, 2020 © 2020 American Medical Association. All rights reserved.

- Healthcare access and quality matter, as do adverse living and working conditions
- Flattening the curve on disparities in health will require long-term, systematic, comprehensive, and coordinated investments in addressing social determinants of health
- Failure to protect the most vulnerable groups of society not only harms them but also increases the spread of infection
- Resistance to the spread of poor health will occur when a sufficiently high proportion of individuals across all groups are protected from and thus "immune" to negative social factors

Williams DR, Cooper LA. JAMA. 2020 May 11. doi: 10.1001/jama.2020.8051

# Reducing Racial Inequities in Health: Using What We Already Know to Take Action

- 1. Create "communities of opportunity"
- 2. Build more health into the delivery of health care
  - Ensure access to high quality care for all
  - o Diversify the healthcare workforce
  - Strengthen preventive and primary care
  - Address patient's social needs as part of healthcare delivery
- 3. Raise awareness of inequities and build political will to address them

Williams DR, Cooper LA. Int J Environ Res Public Health. 2019;16(4):606.





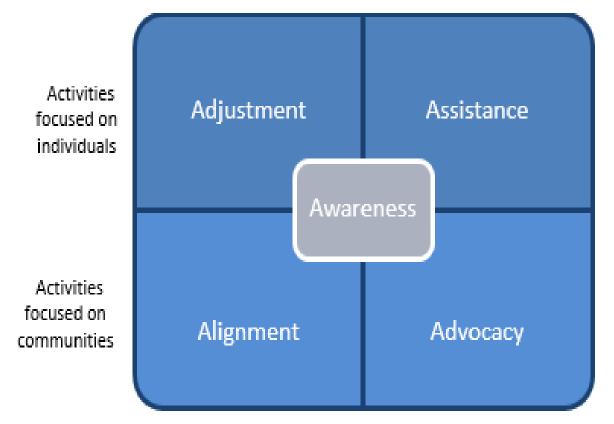
## Race and Ethnic Diversity of Nurses and Primary Care Physicians vs. U.S. Population

Group	White	Asian	Black	Hispanic	American Indian
U.S. Population <sup>1</sup>	61.1	5.4	12.3	17.8	0.7
<b>Registered Nurses<sup>2</sup></b>	80.8	7.5	6.2	5.3	0.4
NPs or Midwives <sup>3</sup>	77.8	7.9	6.9	1.0	0.2
<b>Primary Care Physicians</b>	61.4	21.1	7.3	7.6	0.4

- 1. American Community Survey, datacensus.gov
- 2. The 2017 National Nursing Workforce Survey
- 3. <u>https://datausa.io/profile/soc/2911XX/#ethnicity</u>
- 4. AAMC, 2018



## Five Activities to Facilitate Integration of Social Care into the Delivery of Health Care



INTEGRATING SOCIAL CARE INTO THE DELIVERY OF HEALTH CARE

**MOVING UPSTREAM TO IMPROVE THE NATION'S HEALTH** 

The National Academies of SCIENCES • ENGINEERING • MEDICINE

# Building Trust in Health Systems to Eliminate Health Disparities

TRUST IN HEALTH CARE
Building Trust in Health Systems to Eliminate
Health Disparities
Health systems play a vital role in enhancing the health
Achieving equitable outcomes requires eliminating
the communities they serve, including historically unhealth disparities and obligate that health systems move

Donald E. Wesson, MD, MBA

Department of Internal Medicine, Texas A&M

Medicine Dallas and

laylor Scott & White

Center, Dallas, Texas.

atherine R. Lucey,

iversity of California

ternal Med

San Francisco.

Lisa A. Cooper, MD,

Department of

Hopkins School of Medicine, Baltimore,

Department of Health,

Behavior, and Society, Johns Hopkins

Baltimore Maryland

Author: Donald E. Wesson, MD, MBA,

Baylor Scott & White

Health and Wellness Center, Texas A&M Health Sciences Cen

ollege of Medicine

allas, TX 75210

foomberg School of

Medicine, Johns

Maryland; and

Public Health,

Health College of

derserved populations with disparate health outcomes. beyond their traditional roles of simply providing high Eliminating health disparities is a critical aspect of enhancquality health care to promoting equitable health and ing population health that requires collaborative input from health outcomes. Committing to a shared vision of elimimultiple entities including health systems, government nation of health disparities provides health system leadagencies, community organizations, and residents. A lack ers with opportunities to work collaboratively with nonof clarity among contributing entities about the roles and health system partners to leverage resources addressing responsibilities of health systems in addressing root causes health-related social needs, such as nutrition, housing, and of health disparities make the challenging goal of elimi-transportation, toward improved health outcomes for all nating them even more so. This raises questions in com- populations and even greater improvements for disadmunities served about the extent to which health sys- vantaged groups. Because many needed non-health systems are truly committed to advancing health. The tem resources are in communities that are served by resulting tension compounds the historic lack of trust be-health systems, this provides the opportunity for health tween health systems and underserved communities and system/community partnerships. undermines collaborative work toward mutually beneficial outcomes of improved health. Health system leaders Align Purposes for Eliminating Health Disparitie need to lead in addressing this tension by building and sus- While there is a clear moral argument for eliminating taining trust with and for their communities. health disparities, health system leaders face the more immediate challenge of maintaining the economic health Opportunities to Resolve the Tension of their systems and so might see little incentive to part-Develop a Common Understanding of "Disparities" ner with non-health care entities to help eliminate health Underserved communities see and have devastating efdisparities. The transition from our current fee-for-service fects of disproportionately poor health outcomes that reimbursement system to value-based care (VBC)<sup>3</sup> offers compromise quality of life and financial productivity. Because communities support health system finances align purposes for eliminating health disparities. A VBC through third-party payment, tax incentives associated with nonprofit status, and personal participation in communities. Exposures to negative social determinants their research and education missions, they reasonably of health disproportionately cause poor health outcomes believe that health systems can and should address the for underserved populations.<sup>4</sup> Such a reimbursement enmyriad causes of poor health outcomes to achieve health vironment will incentivize health systems to mitigate equity. Many health system leaders similarly recognize these factors, in contrast to the traditional health care dethe complex causes of health disparities but view their livery model that does not routinely address healthrole in eliminating them as confined to equitable provi- related social needs.<sup>5</sup> To address social determinants of sion of health care across populations they serve. health and achieve VBC through eliminating health dis-A focus on health care delivery as the primary way by parities, health systems must reach beyond boundaries which health systems contribute to eliminating health dis- of clinical care to communities they serve.<sup>6</sup> The evolving parities has limitations. First, it focuses only on individu-focus on VBC incentives provides a common vision, and als already engaged with the health system. Historically un-shared mental model, around which health systems and derserved populations continue to have limited access to communities can align to eliminate health disparities. primary care and a greater reliance on expensive and frag-Health system leaders have the opportunity to lead mented health care services.<sup>1</sup>Second, this focus is reactive in establishing a shared mental model of the specific disand so misses opportunities to prevent adverse health out-parities to be eliminated, and the rationale for doing so, that comes rather than treat them once they have arisen. Third, enables aligning purposes for eliminating health dispari it is costly. Consequently, strategies that focus on health ties. In doing so, they will help their collaborators see that care delivery have not been successful in enhancing popu-although health systems play an important role, their work lation health.<sup>2</sup> Reliance on strategies that optimize the process of health care delivery but do not improve population all populations. This proactive effort will help set the stage health outcomes may be viewed by the community as evi1. Nurture trust-based relationships

- 2. Establish institutional commitment
- 3. Adopt co-production models
- 4. Measure progress toward agreed upon areas of focus

5. Establish supporting systems for accountability

Wesson DE, Lucey CR, Cooper LA. JAMA. 2019;322(2):111-112.

ers must then work in partnerships to imbed effective and

JAMA July 9, 2019 Volume 322, Number 2 111

dence that commitments of health system leaders to im-ticularly among underserved communities. System lead-

© 2019 American Medical Association, All rights reserved

proving health are shortsighted or disingenuous.

#### Relationship-centered care

Self-awareness Knowledge of patients, research participants, colleagues, and partners Participatory communication Respect for individuals Shared values and identities

#### Structural competency

Awareness of health inequities and societal injustices Authentic community partnerships Organizational transparency Funding for health disparities work Diverse participation and leadership

Trust

Cooper LA, Crews DC. COVID-19, racism, and the pursuit of health care and research worthy of trust. J Clin Invest. 2020;141562

Trustworthiness

Integrity

Benevolence

Competence

# Nursing's Role in Advancing Health Equity

### Clinical practice

 Nurses can assess SDOH in the clinical context and advocate for communitybased resources/case management for vulnerable populations.

### Research and Quality Improvement

- Nurses are well-positioned to design and implement community-engaged studies to achieve health equity
- Nurses can design quality improvement projects across different contexts to reduce disparities in health outcomes

### Workforce and training issues

- Achieving health equity requires increasing racial/ethnic diversity in nursing.
- Health equity should be threaded across nursing curricular from pre-licensure to advanced practice /doctoral education

### Leadership and Advocacy

 Nurses represent the largest segment healthcare workforce and should be socially and politically engaged in advocacy efforts to address SDOH HEALING, HEALTH, PEACE + JUSTICE IN 2020 Making big leaps towards #HealthEquity for All







## **STAY CONNECTED**



f

- www.healthequityhub.org
- @JHhealthequity
- @JHhealthequity

