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Healthy People 2030: Addressing Health Disparities and Inequities

OVERVIEW

The United States has become increasingly diverse in the last century. According to the 2010 U.S. Census, approximately 36 percent of the population belongs to a racial or ethnic minority group. Though health indicators such as life expectancy and infant mortality have improved for most Americans, some minorities experience a disproportionate burden of preventable disease, death, and disability compared with non-minorities. Within the past decade, there has been a growing emphasis on trying to understand the causes of health disparities. Although more is known today than in the past, the causes of health disparities are still complex, multidimensional, and poorly understood.

Addressing health disparities is not only important from an equity standpoint, but also for improving the nation's overall health and economic prosperity. This session provides an introduction to what health and health care disparities are, why it is important to address disparities, what the status of disparities is today, recent federal actions through Healthy People 2023 to address disparities, strategies to address disparities in senior living, assessment and competency tools providers can use to address disparities, and some key issues related to addressing disparities to think about as we look ahead.

LEARNING OUTCOME AND OBJECTIVES: Upon completion of this course, you should be able to:

- Cite the detrimental effects that health disparities and inequities have on clients living in long term care (LTC) settings.
- Identify essential principles of Healthy People 2030.
- Outline evidence-based strategies to decrease health disparities and inequities in LTC settings.
- Using case examples, describe how health literacy impact health disparities and inequities.

DEFINITIONS

Health Disparities: The statistical difference in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States. USDHHS

Health Inequities: Disparities in health that result from social or policy conditions that are unfair or unjust.

Health Equity: Health equity is achieved when no one is limited in achieving good health because of their social position or any other social determinant of health. The goal of health equity is to eliminate health inequities that are avoidable and unjust through proactive and inclusive processes.

Social Determinants of Health (SDOH): Social determinants of health (SDOH) are the overarching factors in society that impact health. SDOH include:

- Secure employment, safe, bias-free working conditions and equitable living wages;
- Healthy environment, including clean water and air;
- Safe neighborhoods and housing;
- Food security and access to healthy food;
- Access to comprehensive, quality health care services;
- Access to transportation;
- Quality education;
- Access to a social support network.

Inequities in access to SDOH are a result of structural racism, sexism, homophobia, transphobia, poverty, stigma, and other forms of oppression that are perpetuated by current social structures and institutions.

Structural Racism: The combination of public policies, institutional practices, social and economic forces that systematically privilege white people and disadvantage Black, Indigenous and other people of color. This term underscores that current racial inequities within society are not the result of personal prejudice held by individuals. Adapted from Aspen Institute and Bailey, Feldman, Bassett

INTRODUCTION

Healthy People 2030 defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."

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. Health disparities exist in all age groups, including older adults. Groups like the Centers for Disease Control and Prevention (CDC) are aware that even though life expectancy and overall health have improved in recent years for most Americans, not all older adults are benefitting equally because of factors such as economic status, race, and gender. Researchers acknowledge that this is a growing problem, and our healthcare system and government agencies are trying to incorporate these issues into our work.

Healthy People defines health equity as "the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

When we talk about these terms, it's helpful to imagine a group of people of different heights, ages, and abilities standing behind a tall fence trying to see over it. Equality is giving everyone the same size box to help them see over the fence. Equity is giving each person what they need to see over the fence—for example, a shorter person may need two boxes, whereas a taller person may need no boxes. In looking at equality, the assumption is that everyone benefits from the same supports. This is equal treatment. When looking at equity, everyone gets the supports that they need. This is the concept of affirmative action thus producing equity. And finally with regard to justice, in this example, all three can see the game without

supports or accommodations because the cause or causes of the inequity were addressed. The systemic barrier has been removed. The goal of Healthy People 2030 is to remove systemic barriers and remove the fence altogether.

DISPARITIES VS. INEQUITIES

What is the difference between health disparities and health inequities? The definitions for health disparities and inequities might sound strikingly similar, but the relationship between the two is the difference. Health inequities are responsible for many of the health disparities that affect minorities and underserved people. Health *disparities*—such as increased rates of a certain condition or more negative healthcare experiences confined to a certain populations are often driven by social and economic *inequities*, such as racial discrimination, access to nutritious food, safe drinking water, and proper education. So, the difference between health disparities and inequities is that the latter causes the former.

Addressing disparities in health care is important not only from an equity standpoint but also for improving the nation's overall health and economic prosperity. People of underserved groups experience higher rates of illness and death across a wide range of health conditions, limiting the overall health of the nation. Research further finds that health disparities are costly, resulting in excess medical care costs and lost productivity as well as additional economic losses due to premature deaths each year.

Despite the recognition of disparities for decades, many disparities have persisted, and, in some cases, widened over time. Disparities are still prevalent for racial, ethnic, and socioeconomic groups for all dimensions of quality of and access to care, many types of care and care settings, and leading clinical conditions and subpopulations. Although some disparities are diminishing, others are increasing.

Examples include:

- Underserved groups more likely to be uninsured.
- Underserved groups continue to experience many disparities in accessing and receiving care.
- Underserved groups face ongoing disparities in health.
- COVID-19 took a disproportionate toll on the health and well-being of people of underserved groups.
- Mental health concerns and substance use have increased among underserved groups.

Despite large gains in coverage since implementation of the Patient Protection and Affordable Care Act (ACA) in 2014, underserved groups remain more likely to be uninsured. Underserved groups continue to experience many disparities in accessing and receiving care. For example, people in rural areas face barriers to accessing care due to low density of providers and longer travel times to care, as well as more limited access to health coverage. There also are inequities in experiences receiving health care across groups. For example, the KFF/The Undefeated 2020 Survey on Race and Health, found that one in five Black adults and one in five Hispanic adults report being treated unfairly treatment due to their race or ethnicity while getting health care for themselves or a family member.

Underserved groups face ongoing disparities in health. For example, at birth, American Indians/Alaska Natives (AIAN) and Black people had shorter life expectancies compared to White people as of 2021, and AIAN, Hispanic/Latinx, and Black people experienced larger declines in life expectancy than White people between 2019 and 2021, reflecting the impacts of COVID-19. Although Black people did not have higher cancer incidence rates than White people overall and across most types of cancer, they were more likely to die from cancer in 2019. There are also stark disparities in health by income. Research shows

that people living in areas with high concentrations of poverty are at increased risk of poorer health outcomes over the course of their lives.

The COVID-19 pandemic took a disproportionate toll on the health and well-being of people of underserved groups. Data showed that AIAN and Hispanic/Latinx people have had a higher risk for COVID-19 infection and AIAN, Hispanic/Latinx, and Black people had a higher risk for hospitalization and death due to COVID-19. Beyond these direct health impacts, the pandemic has negatively impacted the mental health, well-being, and social and economic factors that drive health for Black, Indigenous, and people of color (BIPOC) and other underserved groups.

Mental health concerns and substance use have increased among underserved groups. Over the course of the pandemic, many adults reported symptoms consistent with anxiety and depression. Additionally, drug overdose deaths have sharply increased and after a brief period of decline, suicide deaths are once again on the rise. These negative mental health and substance use outcomes have disproportionately affected some populations, particularly communities of color. Drug overdose death rates were highest among AIAN and Black people as of 2021. Alcohol induced death rates increased substantially during the pandemic, with rates increasing the fastest among BIPOC and people living in rural areas. From 2019 to 2021, many BIPOC experienced a larger growth in suicide death rates compared to their White counterparts (Ndugga & Artiga, 2023).

CONTRIBUTING FACTORS

Evidence on disparities is often classified by contributing factors, including person characteristics; health care; environment; and the systemic factors of poverty, oppression, and discrimination. Many factors drive disparities in health and health care. Though health care is essential to health, research shows that health outcomes are driven by multiple factors, including underlying genetics, health behaviors, social and environmental factors, access to health care, and systemic factors like poverty, oppression, and discrimination. While there is currently no consensus in the research on the magnitude of the relative contributions of each of these factors to health, studies suggest that health behaviors and social and economic factors, often referred to as social determinants of health, are the primary drivers of health outcomes and that social and economic factors shape individuals' health behaviors.

Person characteristics were long believed to be a primary explanation for health disparities. For years, people claimed that racial differences in the genetic makeup of people explained disparities as a biological variable; now, growing evidence increasingly supports race as a social category. For example, groups with similar physical characteristics, like skin color, vary greatly in their genetic makeup and, thus, in their predisposition to disease.

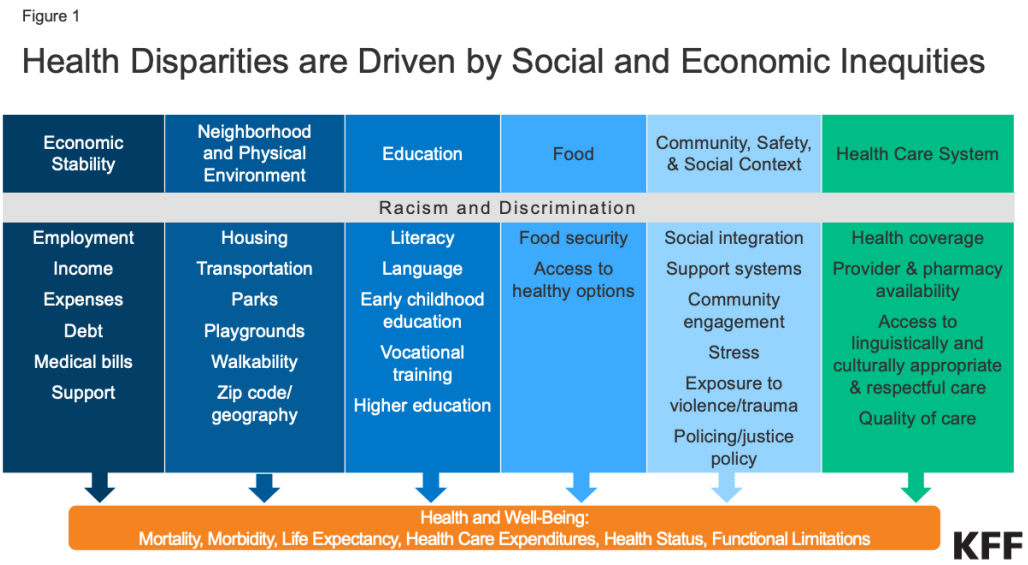
The U.S. health system and practices have come under increasing scrutiny for their contributions to disparities. The health care environment contributes to disparities through many factors, including access, insurance, linguistic barriers, and complex bureaucracies. The clinical encounter itself is also a contributing factor. There is a large amount of evidence of differences in quality of care for different racial and ethnic groups for clinical conditions. Practitioners' clinical uncertainty, beliefs or stereotypes, time pressure, limited or incomplete information, and high demand on attentional or cognitive processes were contributing factors to care discrepancies in addition to possible biases and prejudices. Clients also bring their own background, beliefs, and values to the clinical encounter, and these are shaped by previous negative experiences, limited familiarity with diseases and treatment options, culturally determined health beliefs, or lack of interpreters.

Environmental factors such as air and water quality are fundamental determinants of our health and well-being. Environmental factors can lead to disease and health disparities when the places where people live, work, learn, and play are burdened by social inequities. Environmental health disparities exist when communities exposed to a combination of poor environmental quality and social inequities have more sickness and disease than wealthier, less polluted communities. As an example, people with low incomes are more likely to live in polluted areas and have unsafe drinking water. And children and pregnant women are at higher risk of health problems related to pollution.

The root factors of poverty, oppression, and discrimination are central to any discussion of health disparities. According to the U.S. Census, the official poverty rate in 2022 was 11.5 percent, with 37.9 million people in poverty. Poverty affects health by limiting access to proper nutrition and healthy foods; shelter; safe neighborhoods to learn, live, and work; clean air and water; utilities; and other elements that define an individual's standard of living. Research suggests that discrimination impacts health primarily through psychosocial stress, access to health and social resources, and violence and bodily harm. These pathways interact with one another. For instance, denied access to jobs and housing is a cause of psychosocial stress.

This graphic shows us different social and economic inequities that contribute to health disparities.

Figure 1



Health disparities are associated with a broad, complex, and interrelated array of factors, and may reflect:

- Age
- Race
- Ethnicity
- Socioeconomic status
- Disability status
- Identity and expression* (e.g.,gender, racial, ethnic)
- Geographic location (e.g., rural or urban environment)
- Education
- Health care (e.g.,access, quality)
- Culture (e.g.,norms, traditions, collective responses)
- Health behaviors (e.g.,smoking, violence, substance abuse)
- Biological (e.g., sex, chronic inflammation, telomere attrition, cellular senescence)
- …Or a combination of these

Research also suggests that disparities occur across the life course, from birth, through mid-life, and among older adults. Efforts to reduce disparities focus on priority populations, including, members of underserved communities. These groups are not mutually exclusive and often intersect in meaningful ways. Disparities also occur within subgroups of populations. For example, there are differences among Hispanic/Latinx people in health care based on length of time in the country, primary language, and immigration status.

Let's examine this a little more closely.

In 2015, the National Institute on Aging (NIA) developed and adopted its new "NIA Health Disparities Research Framework" to stimulate the study of environmental, sociocultural, behavioral, and biological factors that influence health disparities related to aging. Many of these factors are broad, complex, and interrelated. The causes of health disparities are dynamic and multidimensional, and to address them adequately, one must consider environmental, social cultural, behavioral, and biological factors.

To address the contribution of these factors to health disparities related to aging, NIA has supported research, for example, that found Alzheimer's disease to be more prevalent among African Americans and Hispanics than among other ethnic groups in the U.S. Other studies have found that lower socioeconomic status is associated with poorer health and reduced lifespan in the U.S. Scientists have also observed sex differences in health and longevity. For example, overall women live longer than men, but are more likely to develop osteoporosis or depressive symptoms or to report functional limitations as they age; men, on the other hand, are more likely to develop heart disease, cancer, or diabetes.

Social environmental factors such as residential segregation, discrimination, immigration, social mobility, work, retirement, education, income, and wealth can also have a serious impact on health and well-being. Economic circumstances can determine whether an individual can afford quality health care and proper nutrition from early life into old age. Individual and family financial resources and health insurance often determine whether an older adult enters an assisted living facility or nursing home or stays at home to be cared for by family members.

The gap in mortality rates between older white and Black adults remains, according to a study published in JAMA Network. The gap has narrowed for individuals in urban areas in the last 60 years. However, the gap has widened between Black and White men living in rural areas during the same period. The National

Cancer Institute highlights disparities in mortality based on educational background: Less-educated individuals from any race are more likely to die from colorectal cancer before 65.

DISPARITIES IN SKILLED NURSING

Disparities in skilled nursing communities reflect both the pre-existing health care disparities in the general community as well as the influence of organizational and reimbursement factors imposed by the nursing community. Disparities in healthcare typically result from the interplay of insurance; healthcare access; health literacy and cultural disparities; and geographic distribution. Residence in the nursing home complicates the situation since it introduces facility differences, regulations, and payer issues. Examples of health disparities affecting older adults include the much lower vaccination rate for influenza and pneumococcus in Hispanics and African Americans compared with that in whites; lower rates of prescriptions for pain control in cancer-related pain for Hispanic and African Americans; and lower rates of procedures for knee and hip replacements, carotid endarterectomies, and coronary-artery bypass grafting for African Americans (Messinger-Rapport, 2009).

Many aspects of the health care system may contribute to these disparities, including lack of or inadequacies in health coverage; lack of access to qualified physicians; lack of health literacy; geographic factors such as rural versus urban or region of the country. Social environmental factors such as residential segregation, discrimination, immigration, social mobility, work, retirement, education, income, and wealth can also have a serious impact on health and well-being. Economic circumstances can determine whether an individual can afford quality health care and proper nutrition from early life into old age. Individual and family financial resources and health insurance often determine whether an older adult enters an assisted living facility or nursing home or stays at home to be cared for by family members.

Numerous studies have shown that nursing facility residents who identify with an underserved population are more likely than other populations to receive poor nursing facility care. The majority of these studies have looked at data across facilities. Several studies look at data within facilities, finding generally that people of color receive poorer care than the facility's other residents. A review of available research demonstrates racial disparities in admissions to nursing facilities, resident hospitalization rates, staffing levels, other quality measures, and COVID-19 infections and deaths. Let's look at some of these issues. This is by no means an all-inclusive list of the issues our clients experience in LTC settings. I just chose a few to highlight.

Researchers have been focusing on admissions to LTC Communities. In general, the research reveals segregation akin to the residential segregation that is endemic in American neighborhoods. Facilities, like residential neighborhoods, are often heavily segregated, with persons of color disproportionately living in a relatively small subset of facilities. A 2018 study, for example, using a data set of hospitalized Medicare beneficiaries, found that nursing facility admissions correlated with race. A full 80% of people of color were admitted to a subset of only 28% of the nursing facilities; similarly, 80% of Latino clients were admitted to 20% of the facilities. Furthermore, these admissions correlated to quality-of-care disparities. Poor quality, as measured by rehospitalization rates, discharge-to-the-community rates, and Medicare star ratings, was more prevalent in facilities with higher percentages of BIPOC. Finally, a 2021 report concluded that Black individuals were less likely to be admitted to high quality nursing facilities, and the disparities were not completely explained by financial and clinical status (Yan et. al, 2021).

WHY ADDRESS DISPARITIES?

Knowing why and how some populations suffer disproportionate health disparities and what role the environment, safe housing, race, ethnicity, education, socioeconomic status, and access play in that suffering can prepare us to begin to alleviate such hardships. Here are reasons why improving the quality of health of everyone should matter and why we all should have a vested interest:

Improving the health of individuals in the most disadvantaged communities improves the overall health of a city or community. Addressing disparities in health and healthcare is important from an equity standpoint and also for improves overall quality of care and population health. If you care about your community, you care about the health disparities that define it.
Improving the health of individuals in our most disadvantaged communities will increase the likelihood that your children will engage with healthy people around the community. With that in mind, addressing health disparities becomes increasingly important as the population becomes more diverse. It is projected that people of color will account for over half (52%) of the population in 2050. Healthier communities lead to safer communities.

Knowledge of health disparities in the most disadvantaged communities helps you and your loved ones avoid the impact of that disparity. Knowledge is power.

Improving the health of individuals in the most disadvantaged communities leads to lower taxes and healthcare costs. Disparities in health lead to unnecessary health care costs that increase financial burdens on taxpayers through the form of Medicaid and emergency room use. Health disparities lead to approximately $93 billion in excess medical care costs and $42 billion in lost productivity per year as well as economic losses due to premature deaths. For example, as of 2018, Latinx individuals are two-and-a-half times more likely to be uninsured than whites (19% vs. 7.5%). People with incomes below poverty are four times as likely to lack coverage as those with incomes at four times the federal poverty level or above (17.3% vs. 4.3%).

In measuring quality, research has focused on the facility's hospitalization rate. In general, an excessive rate of hospitalization may indicate that a facility has been providing inadequate care or has not dedicated sufficient resources to address certain resident conditions. Among residents with severe impairments, Black residents were more likely than white residents to be hospitalized. Overall, the researchers noted the "striking" differences between Black and White residents, "particularly among the most impaired." 80% of Black clients were admitted to only 28% of nursing facilities and these facilities provided poorer quality of care. Another study of hospitalizations found that Black residents had a higher likelihood of being re-hospitalized within the first 30 and 90 days of a nursing facility stay. Overall, Black residents tended to be admitted to nursing facilities with poor performance, limited resources, and high rehospitalization rates. Because disparities mostly related to the facility, both Black and White residents had high re-hospitalization rates within nursing facilities with higher percentages of Black residents (Grunier et al., 2008).

Due in large part to extensive information provided by the Minimum Data Set researchers are able to measure nursing facility quality through a variety of measures. Recent updates to the Minimum Data Set include items to collect data regarding specific social determinants of health that are known to impact

heath equity. These include: Race, Ethnicity, Language, Transportation, Social Isolation, and Health Literacy.

A study on disparities examined quality under three separate metrics: inspection deficiencies, staffing levels, and financial viability. Under each of these measures, Latino residents were found more likely to be residing in a low-quality facility (Fennell et al., 2010). A study on pressure sores found racial disparities both within and between facilities. Black residents suffered higher pressure sore rates than white residents within both facilities that have higher and lower percentages of Black residents. Facilities with higher percentages of Black residents tended to have lower levels of nurse staffing and nurse aide staffing, along with a greater reliance on Medicaid and relatively higher rates of pressure sores across all resident populations, compared to facilities with lower percentages of Black residents (Li et al., 2011).

A study based on antipsychotic use found disparities in relation to Medicaid eligibility but not the resident's race (Black or white) (Fashaw, 2020). Consistent generally with these findings, a study on quality of life found race-based disparities from facility to facility, and within facilities. Compared with white residents in primarily-white facilities, residents of color reported a lower quality of life regardless of the facility's racial makeup (Shippee, 2020).

Older adults who live in LTC settings face various disparities that impact their health. Some disparities include race, socioeconomic status, mistrust of the medical system and the locations of LTC settings (i.e., ZIP codes, rural and urban areas). A study published in the Journal of the American Medical Association found that disparities were greatest in rural settings and that nursing homes with the highest proportion of Black residents were more likely to be for-profit organizations, report staffing shortages, have the highest percentage (about 75%) of residents on Medicaid, have lower RN and aide hours per resident. Other factors included that nursing homes with a large proportion of Black residents were located in communities with a scarcity of resources such as transportation and health services and with low socioeconomic indicators such as education and income along with mistrust in the healthcare system (Travers et al., 2021).

These disparities negatively impact the health of residents. Researchers who studied nursing home disparities across the United States identified an association between underserved populations and negative health outcomes. Since the relationships between various disparities and residents' health is an ongoing issue, it is important to develop more disparity-focused analysis to understand the issues and take specific steps to improve conditions and training for staff serving the residential population.

BURDEN OF DISEASE

Let's examine another example of a health disparity, burden of disease. To assess the health of a population, it is a straightforward approach to focus on mortality, or concepts like life expectancy, which are based on mortality estimates. But this does not take into account the suffering that diseases cause the people who live with them. The sum of mortality and morbidity is called the "burden of disease" by researchers and can be measured by a metric called "Disability Adjusted Life Years" (DALYs). DALYs are standardized units to measure lost health. They help compare the burden of different diseases in different countries, populations, and times. Conceptually, one DALY represents one lost year of healthy life – it is the equivalent of losing one year in good health because of either premature death or disease or disability.

Looking at disease and burden of disease further, it is noted that causes of disparities in diseases, such as asthma and diabetes, include systemic inequities based on race or ethnicity. For example, Black and

Hispanic populations are more likely to have asthma than other U.S. residents. Puerto Ricans, in particular "have the highest rate of asthma prevalence compared to any other racial or ethnic group in the U.S.," according to a report from the Asthma and Allergy Foundation of America. Genetics may play a role in the differences between these populations, but the evidence points to asthma disparities being "significantly rooted in numerous multidimensional social and structural determinants," according to the report.

In another example of health disparities, AIAN have the highest rates of diagnosed diabetes, according to the Centers for Disease Control and Prevention (CDC). Location plays a factor too in that Rural Appalachian regions see higher rates of colorectal, lung and cervical cancers than other parts of the U.S., according to the National Cancer Institute (University of Southern California, 2023).

HEALTHY PEOPLE 2030

So, you might be wondering what we as clinicians and providers can do and what actions we can take to address health disparities and inequities. Now that we have identified that health disparities and health inequities are a widespread issue that affect a large population, where do we go from here?

The federal government has identified health equity as a priority and has since launched initiatives to address disparities. Alongside the federal government, states, local communities, private organizations, and providers have engaged in efforts to reduce health disparities. Moving forward, a broad range of efforts both within and beyond the health care system will be instrumental in reducing disparities and advancing equity. Let's look at one example of a program that is targeting health disparities and health inequities.

Healthy People 2030 is the nation's 10-year plan for addressing our most critical public health priorities and challenges. It was developed by the US Department of Health and Human Service Office of Disease Prevention and Health Promotion. In 1980, the first set of Healthy People 10-year objectives was released. Healthy People 2030 is the fifth iteration of the Healthy People initiative. Healthy People 2030 helps individuals, organizations, and communities committed to improving health and well-being address public health priorities. Healthy People 2030 includes hundreds of measurable objectives with ambitious but achievable national targets.

As Healthy People has evolved over the decades to reflect the most current science and address the latest public health priorities, it has strengthened its focus on health equity. This focus is reflected in one of the overarching goals of Healthy People 2030: "Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all."

Healthy People 2030's emphasis on health equity is closely tied to its focus on health literacy and social determinants of health. Social determinants can affect health literacy and contribute to health disparities. Taking steps to address these factors is key to achieving health equity.

The United States Department of Health and Human Services considered health equity and health disparities throughout the Healthy People 2030 objective development process. To select core objectives, subject matter experts applied specific criteria, including considering how each objective would address health disparities and advance health equity. In addition, the selection criteria for Healthy People 2030 Leading Health Indicators, a subset of high-priority core objectives, required that the indicators address social determinants of health, health disparities, and health equity.

Again, one of Healthy People 2030's overarching goals is to "eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all." To help communities work toward this goal, Healthy People:

- Provides data monitoring tools.
- Highlights evidence-based resources and practices.
- Promotes multisector collaboration.

Each decade, Healthy People tracks progress toward meeting the national disease prevention and health promotion goals and objectives, and it monitors differences across population subgroups. Healthy People data tools summarize and display changes in health disparities to help identify priority populations. Healthy People 2030 also features evidence-based resources focused on strategies that are proven to improve health. These resources include interventions to address public health issues among specific population groups and improve the health of all people.

Healthy People 2030 includes health disparities data for population-based core objectives with available demographic group data. Health disparities are differences in health that are closely linked to social determinants of health. Addressing health disparities is key to achieving health equity and realizing the Healthy People vision of improving the health and well-being of all.

Healthy People 2030 assesses disparities data for population-based core objectives with available demographic group data for a given time point. Healthy People 2030's disparities data feature allows you to track changes in disparities to see where we're improving as a nation and where we need to increase our efforts. This can be accessed at https://health.gov/healthypeople/objectives-and-data/about-disparities-data

Let's consider an example.
In looking specifically at data related to Social Determinants of Health, this can be gathered from the Health Care Access and Quality tab on the Healthy People website. A quick view of this page shows that the overarching goals for Health Care Access and Quality which are to "Reduce the proportion of emergency department visits with a longer wait time than recommended and to increase the proportion of adults who get recommended evidence-based preventive health care."

In drilling down further to topics related to "Health Communication" the objectives are further defined and the status of each objective is identified. Examples of objectives include things like increasing the proportion of adults whose health care providers involved them in decisions as much as they wanted." When you click on that objective, you can see how we are doing as a nation on this objective. As a nation, we are improving the proportion of adults whose health care providers involved them in decisions as much as they wanted. You can click on one of these data tabs to get even more information about this objective.

Evidence-based resources (EBRs) are published reviews of intervention evaluations and studies to improve health. EBRs can help you address public health priorities that you've identified in your work. You can use EBRs to identify specific interventions and actions that have been scientifically assessed on whether they produce the desired change. EBRs are rigorous reviews of the available scientific studies and literature and have been vetted and recommended by national subject matter experts who are leaders in their fields. In addition, EBRs provide information that's credible and applicable to many types of work, and they include specific interventions for both clinical and community implementation. The Healthy People 2030 website organized them into intuitive topics so you can easily find what you're

looking for. Pick a topic you're interested in and explore relevant resources that can help you work to achieve Healthy People 2030 objectives. The evidence-based resources can be found at https://health.gov/healthypeople/tools-action/browse-evidence-based-resources

By going to this website, you can check out the various evidence-based resources to learn about proven, science-based methods to improve health and prevent disease. Providers can use evidence-based resources to guide program development and policies that are informed by evidence on what's effective, replicable, scalable, and sustainable.

Why is this important? Why is this pertinent? These examples walk you through just a few aspects and tools that Healthy People 2023 offers to consumers and providers alike. Providers can access data on this site, access objectives and utilize these to ensure that provider goals are in alignment with national goals, make a comparison of the provider's status toward goals, and utilize the best available evidence-based tools to assist in developing programs in your community that will meet seniors' changing needs. Specifically, providers can use Healthy People 2030 in your community in the following ways:

1. Identify needs and priority populations.
- Browse objectives to learn about national goals to improve health.
- See how national goals align with your priorities.
- Consider focusing on groups affected by health disparities.
- You can use this information to make the case for your program, secure resources, and build partnerships.

2. Set your own targets.
- Find data related to your work.
- Use national data to set goals for your program.
- Healthy People 2030 establishes objectives and targets for the entire United States, but setting local targets contributes to national success.

3. Find inspiration and practical tools.
- Explore critical public health topics relevant to your work.
- Learn about successful programs, policies, and interventions.
- Look for evidence-based resources and tools your community can use.

4. Monitor national progress and use Healthy People 2030 data as a benchmark.
- Check for updates on progress toward achieving national objectives.
- Use HP 2030 data to inform your policy and program planning.
- See how your progress compares to national data.

ADDRESSING DISPARITIES & INEQUITIES IN YOUR COMMUNITY

Numerous studies have found harmful disparities in nursing facility care received by underserved populations. People continue to work to target and reverse these disparities. Policy and organizational strategies are needed to improve residents' Quality of Life (QoL), particularly for underserved residents in communities with high-proportion black, indigenous, and other people of color (BIPOC) with characteristics that place residents at higher risk for diminished QoL. Following are some strategies that providers can implement to decrease disparities and inequities. These recommendations are not intended

to be comprehensive, rather they serve as a jumping off point to improve access, quality of care, and quality of life for our underserved clients, at both systemic and facility levels.

As a first step, we need to understand who our client population is. Increased comprehensive and intersectional data collection and reporting is essential to measure the effectiveness of recommendations and to identify ongoing disparities and develop policies and strategies to address those disparities. Information on residents' quality of life by race/ethnicity could be systematically collected for all Medicare and Medicaid-certified LTC communities. Public reporting mechanisms, such as Care Compare, could provide an avenue for policy change by reporting QoL by race/ethnicity on state-level report cards to incentivize action among states to address disparities and help BIPOC individuals decide where to receive care. To see an example of Care Compare's reporting methods visit https://www.medicare.gov/care-compare/ (Shippee et al., 2022)

Leadership in senior living can implement several strategies to address disparities in an effort to improve health outcomes. Leadership in LTC Communities may need to expand their facilities' programming to include a broader range of activities for all residents and activities specifically for diverse residents such as music, outdoor outings, and culturally sensitive activities. As an example, for the Hmong population, gardening offers safety in the familiar after decades of living with the traumas endured by war, displacement, isolation and anti-Asian sentiments. Gardening is an activity may allow this client population to do something they love to do.

Engage residents with diverse racial/ethnic backgrounds in planning food and activities (e.g., through Resident Councils). Engage diverse community volunteers and family members. Incorporating community input is key to reducing health care disparities. By obtaining the "voice" of culturally diverse residents, providers can inform choices, decisions, and training that occur at the facility-level. Individuals can inform a variety of resources to which they need access in order to remain healthy.
Address systemic racism, stereotyping and bias and its specific impact on health access. In many cases, residents feel that interactions with the medical system were clouded by stereotyping and mistrust. Individuals feel as though they are being condescended to and not being treated as well as others based on their skin color. In addition, many feel like they are being judged negatively and therefore being undertreated. Following are a few quotes from residents residing in post-acute senior living. Education and awareness in our staff can help to override these feelings and provide equitable and fair treatment.

- "We don't want to be stereotyped all the time. We don't want to be judged, and we don't want people always assuming that all of us act the same…"
- "They talk to us like we're different, like we don't understand."
- "I went to a doctor for a lump, like a little small lump or a cyst in my arm. … I left out of there. I had kidney problems. I left there with potassium pills, high blood pressure pills, and the doctor didn't even take time to refer me out to another doctor or to get like testing done or a biopsy or anything. She just looked at the number, statistics that in your age range, African American females had diabetes and high blood pressure."

Implement staff training to help facilitate relationships for new residents, with particular attention to underserved residents without families, residents with limited English proficiency who may be more socially isolated, and those with cognitive impairment. There is a need for cultural competency training. Examples of training might include culturally competent activity planning, meal planning and specific skills such as caring for different hair types. Some facilities offered beautician services, but no staff knew how to care for different hair textures, and residents had to help each other or rely on family for help. Support family and volunteer involvement in the facility. For example, facilities with a high proportion of BIPOC residents may need to leverage BIPOC community-based organizations to combat disparities and

promote transparency. To achieve this, facilities may need to create a welcoming environment for BIPOC residents and develop incentives for volunteers. Initiatives could involve intergenerational connections with BIPOC younger adults where BIPOC older adults could be mentors. Respectful bedside manner is necessary to build trust and better health outcomes. Respectful interpersonal communication between the resident and staff is an enabler of better health outcomes. Individuals deserve to be treated with respect and dignity, to be kept abreast of their health and the plan of care and to be heard by and connected to their clinicians. (Shippee et al., 2022)

Within-facility disparities suggest racial/ethnic bias as a contributing factor. This problem could be addressed by improving training for care staff, including training on recognizing and addressing implicit bias. Although evidence shows that implicit bias contributes to poor care, there are limited studies on the effects of implicit bias training in facilities, due in part to the lack of standardized implicit bias training programs. This may be rectified by developing implicit bias training for use in facilities as part of the required training for nurse aides, nurses, and other facility staff members as well. The effectiveness of implicit bias training and interventions has been scrutinized. In a 2019 systematic review, different types of implicit bias reduction interventions were evaluated. A meta-analysis of empirical studies published between May 2005 and April 2015 identified eight different classifications of training and interventions, the most effective of which were:

- Identifying the self with the outgroup: Participants perform tasks that lessen barriers between themselves and the outgroup.
- Exposure to counter-stereotypical exemplars: Participants are exposed to exemplars that contradict negative stereotypes of the outgroup.
- Evaluative conditioning: Participants perform tasks to strengthen counter-stereotypical associations.
- Inducing emotion: Emotions or moods are induced in participants.
- Intentional strategies to overcome biases: Participants are instructed to implement strategies to over-ride or suppress their biases.

(Carlson & Selassie, 2022; Fitzgerald, et al., 2019)

Address the social determinants of health. Social determinants of health (SDOH) are the elements of a person's life that shape their health. This includes socioeconomic status, education, physical environment, social support network, access to healthcare, and more. SDOH also contributes to health disparities and inequities. For example, people who don't have access to grocery stores are less likely to have good nutrition. As a result, those people are more at risk of heart disease, diabetes, and obesity and may even have a lower life expectancy. The National Academies of Sciences, Engineering, and Medicine outlined a "5As" strategy that healthcare organizations can use to address SDOH in the communities they serve. To summarize:

- Awareness. Providers should focus on identifying the social risks of both specific patients and populations of patients by asking screening questions.
- Adjustment. Instead of directly addressing social needs, organizations can focus on adjusting clinical care, such as by offering evening and weekend clinic access, providing telehealth, using language translators, and more.
- Assistance. Healthcare providers should connect patients with social needs to the appropriate government and community resources.
- Alignment. Healthcare providers should partner with community organizations and invest in systems that positively impact health outcomes.
- Advocacy. Healthcare organizations should advocate for policies that distribute resources to people with social needs.

CULTURAL COMPETENCE

Current regulations and guidance have taken initial steps to incorporate cultural competence. For example, services under a resident's care plan must be "culturally-competent," and care plan interventions for activities must include "resident's choices, personal beliefs, interests, ethnic/cultural practices and spiritual values, as appropriate." Interventions for "psychosocial adjustment difficulties may include… arrangements to keep residents in touch with their communities, cultural heritage, former lifestyle, and religious practices." Food of course is an important element of culture and health; accordingly, menus may "[r]eflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups." A resident who for 85 years has eaten primarily Vietnamese food, for example, or Mexican food, will feel isolated if served generic facility meals. According to this article, one solution would be for surveyors to issue citations for failure to comply with cultural competence standards. In addition, cultural competence should be emphasized in the facility training. Cultural competence should be understood as a necessity rather than a theoretical best practice. (Carlson & Selassie, 2022)

"In reality, many [cultural competency] activities grew organically out of the expressed needs of the community served.... Cultural competency implies the ability to choose what is appropriate for each community from a universe of possibilities. It is always adapting and reinventing itself according to the changing environment... and the expressed needs of the surrounding community" - (HHS HRSA, 2001)

Cultural competency implies the ability to choose what is appropriate for each community from a universe of possibilities. It is always adapting and reinventing itself according to the changing environment... and the expressed needs of the surrounding community" (HHS HRSA, 2001). Things to know about culture:

Culture is learned.
Culture is transmitted from one generation to the next. You learn culture through interactions with others, by listening to, observing, and assessing those interactions. (Carpenter-Song, et al, 2007)

Culture is localized.
It is from such interactions that one identifies and learns what elements – objects in the world, aspects of human relationships, proper behavior, and much more – define the cultural universe one shares with other members of a society. These meaningful elements are shared with some, but not all, individuals within a society.

Culture is patterned.
Patterning (repetition that creates expectations) is essential for successful social behavior and the creation and maintenance of societies. It is essential for individuals within a group to develop patterns for behavior that minimize ambiguity and avoid having to renegotiate every interaction. (Yerxa, 2002)

7 Ways to Improve Cultural Competence:

- Recognize that culture extends beyond skin color
- Find out each patient's cultural background
- Determine your cultural effectiveness
- Make your patients feel “at home.”
- Conduct culturally sensitive evaluations.
- Elicit patient expectations and preferences.
- Understand your cultural identity.

Residents have diverse identities and lived experience, so there is not a one-size fits all approach to client engagement. To build effective and equitable partnerships, health care organizations may want to tailor outreach strategies to effectively reach their populations of focus.

- Design engaging events.
- Foster connections with local champions.
    - In communities where mistrust is often high between residents and the health care system, community champions are essential to help bridge the gap and foster partnerships.

(Spencer & Ohene-Ntow, 2023)

TRAUMA INFORMED CARE

Incorporating the perspectives of clients into health care practices is an essential step in developing an effective trauma-informed approach to care. Trauma results from events or circumstances experienced by an individual (i.e., physical, sexual or emotional abuse; adverse childhood experiences, including neglect and poverty; and discrimination and racism) that result in adverse effects on the individual’s functioning and well-being. A trauma-informed approach to care requires that care teams have a complete picture of a client’s life to provide effective health care. To mitigate the impact of trauma, it is important for care providers to partner with their clients to create a safe physical and emotional environment and co-develop screening and treatment processes to avoid re-traumatization (Spencer & Ohene-Ntow, 2023).

In trauma informed care, healthcare providers and staff need to be cognizant that trauma is extensive and permeates the lives of many patients. Trauma-informed care seeks to change the illness paradigm from one that asks, "What's wrong with you?" to, "What has happened to you?" A program, organization, or system that is trauma-informed realizes the widespread impact of trauma and understands potential paths for recovery; recognizes signs symptoms in clients, families, staff, others involved with system; and responds by fully integrating knowledge about into policies, procedures, practices, and seeks to actively resist re-traumatization.

In a trauma-informed approach, all people at all levels of the organization or system have a basic realization about trauma and understand how trauma can affect families, groups, organizations, and communities as well as individuals. People’s experience and behavior are understood in the context of coping strategies designed to survive adversity and overwhelming circumstances, whether these occurred in the past (i.e., a client dealing with prior child abuse), whether they are currently manifesting (i.e., a staff member living with domestic violence in the home), or whether they are related to the emotional distress that results in hearing about the firsthand experiences of another (i.e., secondary traumatic stress experienced by a direct care professional).

Trauma-informed care means treating a whole person, taking into account past trauma and the resulting coping mechanisms when attempting to understand behaviors and treat the patient. The general public has

little understanding of the ramifications of trauma. The result of this lack of understanding goes beyond an empathy gap or the lack of appropriate response for victims of trauma. It can result in judgmental attitudes and even re-victimization of those who have survived trauma.

Guiding principles of a trauma-informed approach include:

- Reducing barriers: Avoid lengthy assessment processes or asking for personal information before a relationship is built.
- Remaining client-centered: Meet the client/medical staff 'where they are;' collaborate on client and programmatic goals.
- Embracing transparency: Be open about intentions and do not withhold information from clients or providers.
- Building a relationship: Be honest and transparent, offer clients choices, and collaborate with them.
- Avoiding judgment and labels: Classifying someone a "drug abuser" or "non-compliant" makes it difficult to form a trusting, unbiased relationship with clients.
- Staying community based: Reach out to clients in their own environments and ensure meetings take place in a non-hierarchical setting.

What does trauma-informed care look like?
This can mean many things: We should explain why we're asking sensitive questions. We should explain why we need to perform an assessment or test. If someone is nervous, we can let them bring a trusted friend or family member into the room with them. We can tell them that if they need us to stop at any time, they can say the word. If someone refuses outright, or if they're upset about something, we can respond with compassion and work with them, rather than attempting to force them or becoming annoyed. A simple question such as, "Is there anything in your history that makes seeing a therapist or having an evaluation difficult?" or, for those with a known history of trauma, "Is there anything I can do to make your visit/session easier?" can lead to more sensitive practices geared to developing a trusting relationship.

Individuals who have experienced trauma may have difficulty trusting authority figures and tend to fare poorly within traditional health care structures. To engage this group, it is critical to develop a workforce that is aware of the effects of trauma and potential behaviors related to past trauma. Involve patients in the treatment process. In a trauma-informed approach, patients are actively engaged in their care and their feedback drives the direction of the care plan.

It is important for individuals and organizations to approach this work with humility and patience, learn from mistakes, and make improvements to move toward more positive outcomes.
Pivot as necessary. Clients come to our communities with life demands and stressors. They may have a mistrust of care organizations' intentions and goals. It is important for care organizations to have an open mind and adapt partnership approaches with their clients.

Build a culturally sensitive environment. As care organizations work to address health inequities and improve outcomes for clients, cultural humility and sensitivity are required. As an example, to improve vaccination rates among BIPOC and marginalized populations, one care organization in New York partnered with a community resource center for those who have recently immigrated to the community, to host vaccination clinics. During one of the vaccine clinics, a woman requested to receive the immunization from a woman. The provider approached this with sensitivity and found a woman to administer the vaccine (Spencer & Ohene-Ntow, 2023).

As senior living communities increasingly serve a more diverse mix of residents, ensuring equity in quality of life for underserved clients is an urgent priority if these communities will remain relevant in the future. Incorporating lived experience and clients' voices into decision-making processes is a critical element to ensure the equitable delivery of health care services. The most important component when fostering these partnerships is trust. While the approach to client engagement may look different across communities, it is a promising strategy to improve health outcomes and requires humility, patience, cultural sensitivity, and commitment from all levels of the organization.

ADDRESSING HEALTH EQUITY IN TELEHEALTH

It is our shared responsibility to ensure equal access to quality telehealth care for everyone. We can do that through improvements to telehealth workflow, staff training, and community resources. We should also meet the needs of underserved populations in our communities.

Health equity in telehealth is the opportunity for everyone to receive the health care they need and deserve, regardless of social or economic status. Providing health equity in telehealth means making changes in digital literacy, technology, and analytics.

Underserved communities often include:

- Low income Americans
- Rural Americans
- People of color
- Immigrants
- People who identify as LGBTQ
- People with disabilities
- Older patients
- People with limited knowledge of the English language
- People with limited digital literacy
- People who are underinsured or uninsured

Barriers to telehealth access may include:

- Lack of video sharing technology, such as a smartphone, tablet, or computer
- Spotty or no internet access
- Lack of housing or private space to participate in virtual visits
- Few local providers who offer telehealth practices
- Language barriers, including oral, written, and signed language
- Lack of adaptive equipment for people with disabilities
- Equal access in telehealth

There are many ways to improve access to telehealth. This will help new patients feel welcome and comfortable.

- Make materials accessible in different formats and multiple languages.
- Use images and words in your online communications for patients with low literacy.
- Measure patient satisfaction with post-visit surveys to improve service. Knowing what your patients need will help them feel more comfortable with virtual visits.
- Use inclusive patient intake forms that ask about access to technology and patient preferences. This could include language and pronoun preferences.

- Ask if your patients need assistive devices to participate in virtual visits.
- Include accessibility options within your telehealth programs. This could include screen readers or closed captioning options.
- Allow extra time in virtual visit appointments for patients that may need support in getting online.
- Use technology designed with equity in mind when it comes to speech recognition and health prediction algorithms.

HEALTH LITERACY

The Centers for Disease Control and Prevention describe health literacy as the ability to find, understand, and use health information. Health literacy is critical for patients to make informed decisions about their health.

An estimated 90 million Americans have poor health literacy. This population includes many marginalized groups, such as people receiving socioeconomic assistance, non-native English speakers, the elderly, and more. Studies have found that poor health literacy contributes to more health disparities, ineffective use of healthcare services, and a higher risk of mortality.

Health literacy is a multifaceted concept encompassing skills, knowledge, and confidence in accessing, comprehending, and using health information. Health Literacy plays a pivotal role in shaping health outcomes and healthcare utilization. Health literacy includes numeracy skills. For example, calculating cholesterol and blood sugar levels, measuring medications, and understanding nutrition labels all require math skills. Choosing between health plans or comparing prescription drug coverage requires calculating premiums, copays, and deductibles.

In addition to basic literacy skills, health literacy requires knowledge of health topics. People with limited health literacy often lack knowledge or have misinformation about the body as well as the nature and causes of disease. Without this knowledge, they may not understand the relationship between lifestyle factors such as diet and exercise and various health outcomes.

A study conducted on health literacy found that of clients surveyed:

- 43% did not understand the rights and responsibilities section of a Medicaid application
- 26% were unable to understand information on an appointment slip
- 60% did not understand a standard informed consent
- 33% were unable to read basic health care materials
- 42% could not comprehend directions for taking medication on an empty stomach

(Campinha-Bacote, D., 2002):

Healthcare practitioners can assist in ensuring that all health-related information and education provided to clients match that person's literacy abilities; cultural sensitivities; and verbal, cognitive, and social skills. The objectives set forth in the Healthy People 2030 campaign (DHHS, 2013) include ensuring that Healthcare practitioners have appropriate communication and education skills to help enable all people to gain access to and understand Healthcare services. This includes information and education that promote self-management for optimum health and participation. In addition, Healthcare practitioners may facilitate clients' health literacy by promoting systems of care or environments that adhere to health literacy principles and strategies.

There are many strategies to for all healthcare practitioners to address health literacy in your community including and to improve clients' health literacy

1. Be informed about health literacy and recognize it. This refers to practitioners' knowledge and ability to identify challenging health literacy information.

- Learn about health literacy and ways to integrate it into practice.
- Do not assume that all clients understand what they are told even if they nod their head or that they can read
- Recognize the powerlessness, shame and sense of failure that some people may feel. Approach health literacy in an empowering way with your clients
- Identify your client's characteristics (knowledge, teaching preferences, skills, beliefs, culture, barriers, etc.). This is client-centered care.

2. Consider health literacy by making information accessible. This refers to the ability of practitioner to improve how they use information to educate clients.

- Adapt the information to individual needs, circumstances and abilities to show how it is relevant. It is so important that we get to know our clients
- Communicate in a comprehensive way using more than one way of exchanging information. What works for one client may not work for another.
- Combine oral instructions with written information (in clear simple language) for future reference and with a lot of demonstrations including audiovisual aids.
- Use a structured educational approach in order to understand what motivates clients and personalize the treatment plan
- Use demonstration, experimentation and repetition to increase the effectiveness of teaching efforts.

3. Strengthen interactions.

- Encourage clients to ask questions.
- Take an understanding attitude (do not blame) and create a "shame free" safe environment.
- Increase the time spent on giving information (speak more slowly and repeat if necessary), observe and listen actively [stay quiet to give clients time to organize their thoughts, identify their constraints and formulate questions].
- Increase your own cultural competency, i.e. be a professional who respects differences, is open to learning and is willing to admit there is more than one way to look at the world.
- Follow up on interventions to see if recommendations have been followed and if clients have questions.
- Involve not only the client, but also families in treatment.

Did you know that 75 out of 100 Americans can read at the 6th grade reading level without difficulty. What does the reading level score mean? A 4th to 6th grade reading level is readable by most adults. A 7th to 8th grade reading level is readable by half or more adults. A high school and above reading level is only readable by few adults.

As caregivers:

- We need to provide education to our clients. This helps them to be involved in treatment decisions and follow a treatment plan to which they are committed.
- We must be mindful of clients' literacy skills, including their reading ability and comprehension.
- We can formally assess reading ability using quick reading assessments.
- Can informally discuss with clients their previous level of schooling, educational achievement, and perceived reading ability.

HEALTH LITERACY ASSESSMENT TOOLS

The Newest Vital Sign

The Newest Vital Sign (NVS) is a valid and reliable screening tool available in English and Spanish that identifies patients at risk for low health literacy. It is easy and quick to administer, requiring just three minutes. In clinical settings, the test allows providers to appropriately adapt their communication practices to the patient's health literacy level. Researchers have used the instrument to measure health literacy and evaluate the impact of low health literacy on a variety of health outcomes. Accessed at: https://www.pfizer.com/products/medicine-safety/health-literacy/nvs-toolkit

How Does the Newest Vital Sign Work?

The Newest Vital Sign is based on a nutrition label from an ice cream container.

Nutrition Facts

Serving Size	½ cup
Servings per container	4
Amount per serving	
Calories 250	Fat Cal 120
	%DV
Total Fat 13g	20%
Sat Fat 9g	40%
Cholesterol 28mg	12%
Sodium 55mg	2%
Total Carbohydrate 30g	12%
Dietary Fiber 2g	
Sugars 23g	
Protein 4g	8%

*Percentage Daily Values (DV) are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

Ingredients: Cream, Skim Milk, Liquid Sugar, Water, Egg Yolks, Brown Sugar, Milkfat, Peanut Oil, Sugar, Butter, Salt, Carrageenan, Vanilla Extract.

Patients are given the label and then asked 6 questions about it. Patients can and should refer to the label while answering questions. The questions are asked orally and the responses recorded by a health care provider or researcher on a special score sheet, which contains the correct answers. Based on the number of correct responses, the health care provider or researcher can assess the patient's health literacy level.

Newest Vital Sign Questions

1. If you eat the entire container, how many calories will you eat?
Answer: 1,000 is the only correct answer

2. If you are allowed to eat 60 grams of carbohydrates as a snack, how much ice cream could you have?
Answer: Any of the following is correct: 1 cup (or any amount up to 1 cup), half the container. Note: If patient answers, "two servings," ask "How much ice cream would that be if you were to measure it into a bowl?"

3. Your doctor advises you to reduce the amount of saturated fat in your diet. You usually have 42 g of saturated fat each day, which includes one serving of ice cream. If you stop eating ice cream, how many grams of saturated fat would you be consuming each day?
Answer: 33 is the only correct answer

4. If you usually eat 2,500 calories in a day, what percentage of your daily value of calories will you be eating if you eat one serving?
Answer: 10% is the only correct answer

READ TO SUBJECT:
Pretend that you are allergic to the following substances: penicillin, peanuts, latex gloves, and bee stings.
5. Is it safe for you to eat this ice cream?
Answer: No

6. (Ask only if the patient responds "no" to question 5): Why not?
Answer: Because it has peanut oil

You might be wondering why an ice cream label?
Whether reading a food label or following medical instructions, patients need to:
Remember numbers and make mathematical calculations
Identify and be mindful of different ingredients that could be potentially harmful to them
Make decisions about their actions based on the given information.

What Can Providers Do to Improve Patient Understanding?
If the Newest Vital Sign results indicate a patient has limited health literacy skills, providers can use clear health communication techniques to help patients better understand their medical issues and follow instructions.

Test of Functional Health Literacy in Adults
The Test of Functional Health Literacy in Adults (TOFHLA) (Parker et al., 1995) is accessed at file:///C:/Users/Manager/Downloads/Attachment%20D%20-%20Short%20Test%20of%20Functional%20Health%20Literacy%20in%20Adults%20(STOFHLA).pdf
This tool measures numeracy and reading comprehension using prescription bottles, appointment slips, Medicaid applications, and the like.

Rapid Estimate of Adult Literacy in Medicine
Another health literacy assessment tool is the Rapid Estimate of Adult Literacy in Medicine (REALM) (Andrus & Roth, 2002) which identifies a medical word recognition system. This tool is accessed at: https://www.ahrq.gov/health-literacy/research/tools/index.html#rapid
This tool doesn't assess reading comprehension.

REALM-SF Score Sheet

Patient ID #: _____ Date: _____ Examiner Initials: ____

Behavior	____
Exercise	____
Menopause	____
Rectal	____
Antibiotics	____
Anemia	____
Jaundice	____
TOTAL SCORE	_____

Administering the REALM-SF:

Suggested Introduction:

"Providers often use words that patients don't understand. We are looking at words providers often use with their patients in order to improve communication between health care providers and patients. Here is a list of medical words.

Starting at the top of the list, please read each word aloud to me. If you don't recognize a word, you can say 'pass' and move on to the next word."

Interviewer: Give the participant the word list. If the participant takes more than 5 seconds on a words, say "pass" and point to the next word. Hold this scoring sheet so that it is not visible to the participant.

Scoring:
0 = Third grade and below; will not be able to read most low-literacy materials; will need repeated oral instructions, materials composed primarily of illustrations, or audio or video tapes.
1-3 = Fourth to sixth grade; will need low-literacy materials, may not be able to read prescription labels.
4-6 = Seventh to eighth grade; will struggle with most patient education materials; will not be offended by low-literacy materials.
7 = High school; will be able to read most patient education materials.

EFFECTIVE VERBAL AND WRITTEN COMMUNICATION

Effective verbal and written communication is a crucial component of health literacy. Ask Me 3® is an educational program that encourages clients and families to ask three specific questions of their providers to better understand their health conditions and what they need to do to stay healthy. The questions are:

1. What is my main problem?

2. What do I need to do?

3. Why is it important for me to do this?

This program was designed by health literacy experts, Ask Me 3 is intended to help clients become more active members of their health care team, and provide a critical platform to improve communications between clients, families, and health care professionals. These questions will help the clinician to develop client-centered goals.

Another method we can employ is the Teach Back method. Using this tool, the client repeats the information in his, her or they own words to show understanding. It is useful to assess your own communication skills with the client. The clinician would have the client:

- Tell me what you have understood.
- I want to make sure that I have explained what I would like you to do for your Therapy Plan clearly.
- Can you tell me how you are going to do your exercises or plan at home?
- Can you show me how you are going to do your exercises?

When developing written materials, aim for a 5-6th grade reading level. If you're not sure what the reading level is of a paragraph or material, most word processing programs including Microsoft Work offer readability statistics including grade reading level. Some things to keep in mind when designing written materials:

Content

- Ensure the purpose is immediately outlined and clear to the reader.
- Ensure content is balanced, accurate, and up-to-date.
- Include a publication or revision date on all materials.
- Provide how-to information of relevance to the reader's situation.

Organization

- Use subheadings, question and answer format, bullet points, and summaries

Layout

- Use ample white space.
- Use serif typefaces, minimum 12-point font size, good contrast between text and background.
- Avoid capitalizing all letters in words, italicizing, and the use of Roman numerals.

Illustrations

- Use instructive, culturally appropriate illustrations but only if they augment the message
- Position illustrations next to the text they refer to.
- Clearly label all illustrations.

Tips to Write for All Readers:

- Use plain English
- Make every word count and cut out any unnecessary words
- Be clear and brief
- Use positive words – for example, do, not no and don't
- Short lists or bullet points, not long sentences
- Concrete, familiar words, except for necessary technical terms
- Charts and pictures
- One or two syllable word when possible – for example, hard rather than difficult

The way your text looks greatly affects readability. Choosing the appropriate font style and size is important in creating health communication materials that are easy to read.

1. Use font sizes between 12 and 14 points.
   Anything less than 12 points can be too small to read for many audiences. Older people and people who have trouble reading or seeing may need larger print.
2. For headings, use a font size at least 2 points larger than the main text size.
3. Font Style
   For the body of the text, use fonts with serifs. Serif fonts are usually easier to read than sans-serif fonts. This is because the serif makes the individual letters more distinctive and easier for our brains to recognize quickly. Serifs are the little "feet" on letters.

Keep the following style tips in mind:

- Do not use FANCY or script lettering.
- Use both upper and lower case letters. Do not use ALL CAPS. ALL CAPS ARE HARD TO READ.
- Use grammatically correct punctuation.
- Use bold type to emphasize words or phrases.
- Limit the use of italics or underlining. They are hard to read.
- Use dark letters on a light background. Light text on a dark background is harder to read.

HEALTH EQUITY COMPETENCIES FOR PROVIDERS

Health Equity Competencies will be useful to all health care providers who seek to promote health equity in any health care setting. It is not expected that every patient encounter will address all of these competencies. Providers should review each item, think about the realities faced by their patient population and consider which competencies they can begin to address, and which they would need additional support or training to implement.

Addresses Social Determinants of Health (SDOH)

- Recognizes that structural racism, unfair criminal justice practices, and other systems of oppression result in inequitable access to SDOH which, in turn, play a significant role in individual and community health outcomes.

- Assesses SDOH at baseline and annually. Makes needed referrals to community resources for assistance with: housing; accessing healthy food; transportation; vocational services; income maintenance; health coverage; social support, etc.
- Actively collaborates with care managers, peer workers and community health workers in efforts to address SDOH for each patient.

Takes an Active Role in Community and Institution

- Actively engages with the community and seeks out information about conditions, resources, priorities, assets and barriers that impact the health of their patients.
- Advocates within the health care institution for policies and procedures that will promote an inclusive environment and health equity.
- Actively uses multiple data sources to identify, set goals and address inequities related to health outcomes.
- Works to destigmatize and normalize mental health, substance use issues and services.
- Advocates for addressing the impact of trauma on health, including historical trauma and recent trauma.

Employs a Person-Centered Model of Care

- Uses Clear Communication to convey health information.
- Makes time to listen and actively supports patient self-determination using an autonomy supportive approach.
- Integrates at least one of the following models of care into patient interactions:
- Harm Reduction Approach
- Trauma-Informed Care
- Stages of Change or Motivational Interviewing

Seeks to Avoid Bias and Provides Affirming Services

- Seeks out information and continuing education on the impacts of systemic racism on health and well-being.
- Can identify how structural factors influence health outcomes, and understands race as a social construct, not a biological determinant of health.
- Acknowledges the universal nature of implicit bias and uses at least one tool for examining their own implicit bias.
- Is aware of the history of exploitation of people of color for purposes of medical research. Builds trust by practicing full disclosure regarding medications, treatments and procedures.
- Is aware of the adverse effects of trauma on health and practices trauma-informed care.
- Is on alert to identify instances of sexual violence, domestic violence, and abuse, and makes referrals as needed.
- Is comfortable talking about sexual orientation and gender identity and provides affirming care to LGBTQ+ patients.
- Is comfortable talking about substance use and provides affirming care to people who use drugs.
- Uses the patient's preferred pronouns and person-first, affirming language, for example, person living with HIV.
- Provides or facilitates access to stigma-free sexual health services and reproductive choice.
- Demonstrates respect to people with a history of criminal justice involvement by avoiding stigmatizing language and behaviors.
- Explains the scope and limits of legal protections against sharing health information, and reassures undocumented people that health information is not shared with ICE.

- Knows when to request, and how to use, a language interpreter when serving patients whose primary language they do not speak.
- Knows when to request, and how to effectively use, an American Sign Language interpreter.
- Actively uses affirming statements during clinical encounters to demonstrate they recognize the inherent value of every patient.

CONCLUSION

On top of being costly, disparities hinder the nation's overall health, as groups who historically have had access to fewer resources have higher rates of illness and death from a variety of preventable conditions. Working to close gaps in health and health care will take community and legislative efforts. But just as important are conversations everyone can have each day to raise awareness.

Addressing disparities in health and health care is important not only from an equity standpoint but also for improving the nation's overall health and economic prosperity. People of color and other underserved groups experience higher rates of illness and death across a wide range of health conditions, limiting the overall health of the nation. Research further finds that health disparities are costly, resulting in excess medical care costs and lost productivity as well as additional economic losses due to premature deaths each year. Racial health disparities result in about $93 billion in excess medical care costs and $42 billion in lost productivity each year, according to a 2018 analysis from the W.K. Kellogg Foundation and the nonprofit Altarum.

It is increasingly important to address health disparities as the population becomes more diverse and income inequality continues to grow. It is projected that people of color will account for over half (52%) of the population in 2050, with the largest growth occurring among people who identify as Asian or Hispanic. Over time, the population has become increasingly racially diverse, reflecting shifting immigration patterns, a growing multiracial population, as well as adjustments to how the federal Census Bureau measures race and ethnicity.

But, while health and health care disparities are often viewed through the lens of race and ethnicity, but they occur across a broad range of dimensions. For example, disparities occur across socioeconomic status, age, geography, language, gender, disability status, citizenship status, and sexual identity and orientation. Research also suggests that disparities occur across the life course, from birth, through mid-life, and among older adults.

We, as practitioners and providers need to ensure health-related information/education matches person's literacy abilities; cultural sensitivities; and verbal, cognitive, and social skills. Caregiving organizations should provide information and education that promote self-management for optimum health and participation. We can facilitate health literacy by promoting systems of care or environments that adhere to health literacy principles and strategies. Effective health communication involves providing health care-related information to an individual in an understandable and accessible way that increases his, her or they knowledge related to health, with the goal of positively influencing the individual's health behaviors and attitudes. If we can get a handle on health literacy in our communities we just might improve our health outcomes and definitely improve our clients' quality of life.

In conclusion, disparities in health and health care for people of color and other underserved groups are longstanding challenges, many of which are driven by underlying structural and economic disparities rooted in racism. Addressing disparities is key not only from an equity standpoint but for improving the

nation's overall health and economic prosperity. The federal government has identified health equity as a priority and has since launched initiatives to address disparities wrought by the COVID-19 pandemic and more broadly the healthcare system. Alongside the federal government, states, local communities, private organizations, and providers have engaged in efforts to reduce health disparities. Moving forward, a broad range of efforts both within and beyond the health care system will be instrumental in reducing disparities and advancing equity.

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Neely Tolbert Sullivan MPT, CLT-LANA, CDT, has worked with diverse client populations ranging from pediatric to geriatric in a variety of clinical settings. These experiences have allowed her to treat and develop effective client care programs. She has served in multiple levels of regional and corporate management positions. In these positions, Neely has developed policies and worked closely with interdisciplinary teams to ensure that all clients have the opportunity to attain their highest level of function and quality of life. She has most recently been responsible for the identification, implementation and evaluation of clinical programs in long-term care settings.

Neely currently provides educational support to 16,000+ therapists nationwide as the Director of Wellness and Education Specialist for Select Rehabilitation. Neely has lectured nationally and at the state level on a variety of clinical and regulatory topics. She has authored publications focusing on evidence-based practice and clinical care. Neely conducts audits, quality improvement planning, and clinical training to Select Rehabilitation employees and customers monthly. She is a member of the APTA including the Clinical Electrophysiology and Wound Management section and Geriatric section.

POST-TEST

1. What is "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage?"
   a) Health inequity
   b) Health disparity
   c) Social determinant of health
   d) Racism

2. Research shows that health outcomes are driven by multiple factors, including:
   a) Health behaviors
   b) Social and environmental factors
   c) Access to health care
   d) All of the above

3. In LTC settings, many aspects of the health care system may contribute to disparities, including:
   a) Adequate health insurance coverage
   b) Access to qualified physicians
   c) Lack of health literacy
   d) Access to clean drinking water

4. In SNF settings, research demonstrates racial disparities in:
   a) Food quality
   b) Access to activities in the community
   c) Staffing levels
   d) Incidents of C-Diff

5. One of Healthy People 2030's overarching goals is to "eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all." To help communities work toward this goal, Healthy People 2030:
   a) Provides site visits to your community
   b) Monitors electronic medical records
   c) Hosts LTC leadership teams at an annual conference
   d) Highlights evidence-based resources and practices

6. How can You Use HP 2030 in Your Community?
   a) Identify needs and priority populations
   b) Set your own targets
   c) Find inspiration and practical tools
   d) All of the above

7. According to Shippee et al., 2022, how can LTC providers know our client population?
   a) Collect information on clients' QoL by race/ethnicity
   b) Be active on social media
   c) Create client profiles
   d) Host community events

8. According to Carlson & Selassie, 2022, how can LTC providers incorporate cultural competency in the community?
   a) Host community events
   b) Collect and respond to customer reviews
   c) Invest in corporate advertising
   d) Have consequences for failure to comply with standards

9. Health literacy includes numeracy skills which are needed to:
   a) Measure medications
   b) Find transportation to appointments
   c) Communicate symptoms of a pathology to a health care provider
   d) Read health related information
   e) Listen actively to health information from a physician

10. As clinicians, we can be aware of the health literacy of our clients by:
    a) Providing education to our clients
    b) Formally assessing reading ability of our clients
    c) Informally discussing with clients their previous level of schooling, educational achievement, and perceived reading ability
    d) All of the above

The post-test and corresponding course evaluation can be accessed at:
https://www.surveymonkey.com/r/Healthy_People_2030_Take_Home

Or by using the following QR Code:

If all course requirements have been met, a certificate will be emailed from Select Rehabilitation to the email address reported in the course follow-up survey.

Any questions or issues related to this course should be directed to Dr. Kathleen Weissberg, National Director of Education for Select Rehabilitation at kweissberg@selectrehab.com