Housekeeping

• Q & A to follow – Submit questions using Q&A area

• Slides are available at https://www.ruralhealthinfo.org/webinars/health-disparities

• Technical difficulties please call 866-229-3239
Featured Speakers

Tom Morris, Director, HRSA Federal Office of Rural Health Policy

Cara James, PhD, Director, CMS Office of Minority Health and co-chair of CMS Rural Health Council

Jeffrey Hall, PhD, MSPH, Deputy Associate Director for Science, CDC Office of Minority Health & Health Equity

Liz Manjarrez, M.Ed., MS, Outreach Projects Administrator at Palo Verde Hospital

Linda Matessino, RN, MPH, Grants Project Director at Innis Community Health Center


Cara V. James, PhD
CMS Office of Minority Health

Jeffrey E. Hall, PhD
CDC Office of Minority Health and Health Equity
Contributing Authors

• Cara V. James, PhD, CMS OMH
• Ramal Moonesinghe, PhD, CDC OMHHE
• Shondelle M. Wilson-Frederick, PhD, CMS OMH
• Jeffrey E. Hall, PhD, CDC OMHHE
• Ana Penman-Aguilar, PhD, CDC OMHHE
• Karen Bouye, PhD, CDC OMHHE

Background

• Health differences have been documented between rural and urban dwelling adults
• Some rural health studies have reported on a particular state or geographic region and have been focused on one or two racial and ethnic populations
• Rural communities are becoming more diverse
  • Limited studies have presented national estimates on the varying health status of racial and ethnic groups among rural dwelling adults
  • Unique health and access to care challenges experienced by rural racial and ethnic populations may be overlooked when data are not analyzed for specific population groups
Background

• Increased attention on rural health issues presents an important opportunity for decreasing disparities in health and health care access between rural and urban communities

• Hispanics, Asians, and NHOPIs represented more than half of the population growth in rural communities (2012)\(^1\)
  • Changing demographics can lead to unmet health needs among new and growing populations
  • Necessary for health care providers to understand and address the unique needs of the populations they encounter


Study Design

• Analyzed 2012-2015 self-reported Behavioral Risk Factor Surveillance System (BRFSS) data from all 50 states and DC on demographic and health characteristics of the US population aged ≥ 18 in rural areas

• Identified counties in the BRFSS through a data use agreement obtained from CDC

• Used 2013 NCHS Urban-Rural classification scheme for counties--categorizes counties as large central metropolitan, large fringe metropolitan, medium metropolitan, small metropolitan, micropolitan, and noncore (rural).
  • There were 1,325 noncore counties and 6.1% of the US population lived in these counties.
  • The study sample for most variables contained 263,054 adult respondents in rural counties

• Used SAS-callable SUDAAN software, which takes into account the complex sample design of BRFSS, to analyze data.
Characteristics Assessed

Demographic Characteristics
- Race/ethnicity
- Age
- Sex
- Marital status
- Educational attainment
- Annual household income
- Employment status
- Census region
- Census division

Health-Related Quality of Life
- Fair or Poor Health Status
- Frequent physical distress (≥14 days in poor physical health in past 30 days)
- Frequent mental distress (≥14 days in poor mental health in past 30 days)
- Activity limitation because of physical, mental, or emotional problems

Health Care Access and Use
- Could not see doctor in past 12 months because of cost
- Health care coverage
- At least one personal doctor or health care provider
- Length of time since last routine checkup
- Cervical cancer screening
- Breast cancer screening
- Colorectal cancer screening

Chronic Health Conditions
- Number of (selected) chronic conditions
- Depressive disorder
- Obesity
- Severe Obesity

Health Behaviors
- Cigarette smoking
- Binge drinking
- No leisure-time physical activity in past month

Selected Findings: Demographic Characteristics

Age
- Compared with rural non-Hispanic whites, rural racial/ethnic minorities were more often in the youngest age category (18-44 years).
  - 66.0% of Hispanics
  - 60.5% of Asians and NHOPIs
  - 49.3% of AI/ANs
  - 43.7% of non-Hispanic blacks
  - 36.9% of non-Hispanic whites

Educational Attainment
- Fewer Hispanics (6.2%), non-Hispanic blacks (8.4%), AI/ANs (8.5%) were college graduates, compared with non-Hispanic whites (16.0%).
- More Asians and NHOPIs (35.4%) were college educated.

Household income
- More non-Hispanic blacks (61.8%), AI/ANs (56.3%), and Hispanics (53.1%) had annual household incomes <$25,000 than non-Hispanic whites (31.8%).

U.S. Census Region
- The largest proportion of 4 out of 5 populations lived in the Southern region
  - 93.9% of non-Hispanic blacks
  - 59.1% of Hispanics
  - 37.0% of Asians and NHOPIs
  - 43.9% of non-Hispanic whites
- The largest proportion of AI/ANs (38.2%) lived in the Western region.
Selected Findings: Health-related Quality of Life

- **Fair or Poor Health Status**
  - Rates of self-reported fair or poor health were higher among AI/ANs (28.9%), non-Hispanic blacks (28.8%), and Hispanics (28.4%) compared with those for non-Hispanic whites (18.5%)
  - This rate was lower among Asians and NHOPIs (10.4%)

- **Frequent Mental Distress**
  - Compared with non-Hispanic whites (12.5%), the prevalence of frequent mental distress was higher among AI/ANs (17.1%) and non-Hispanic blacks (13.9%)
  - This rate was lower among Asians and NHOPIs (5.4%)

Selected Findings: Health Care Access and Use

- **Health Care Coverage**
  - Fewer non-Hispanic blacks (73.2%) and Hispanics (61.1%) reported having health care coverage compared with non-Hispanic whites (83.9%)

- **Could Not See Doctor in Past 12 Months Because of Cost**
  - More non-Hispanic blacks (24.5%), Hispanics (23.1%), and AI/ANs (19.1%) said they could not see a physician when needed because of cost than non-Hispanic whites (15.0%)

- **Cancer Screening**
  - Among women aged 50–74 years, more non-Hispanic black women (77.2%) but fewer Hispanic women (60.1%) had a mammogram in the past 2 years compared with non-Hispanic whites (73.4%)
  - Among those aged 50–75 years, fewer non-Hispanic blacks (53.6%), Hispanics (43.4%), and AI/ANs (53.4%) than non-Hispanic whites (61.7%) were up to date with colorectal cancer screening.
Selected Findings: Health-Related Behaviors

• Cigarette Smoking
  • Fewer Hispanics (17.0%) and Asians and NHOPIs (10.9%) were current smokers than non-Hispanic whites (24.7%)

• Binge Drinking
  • The prevalence of binge drinking was lower among Hispanics (14.3%), non-Hispanic blacks (11.7%), and Asians and NHOPIs (9.9%) than among non-Hispanic whites (16.3%)

Selected Findings: Chronic Health Conditions

• Number of Chronic Conditions
  • More non-Hispanic blacks and AI/ANs (40.3% of both groups) than non-Hispanic whites (36.0%) reported having multiple chronic health conditions.
  • Fewer Hispanics (27.4%) and Asians and NHOPIs (20.7%) reported multiple chronic health conditions.

• Depressive Disorder
  • Depression was more common among AI/ANs (23.2%) than among non-Hispanic whites (20.3%) and less common among non-Hispanic blacks (15.8%), Hispanics (15.9%), and Asians and NHOPIs (5.8%)

• Obesity
  • Obesity and severe obesity (45.9% and 12.1% respectively) were more prevalent among non-Hispanic blacks than among non-Hispanic whites (32% and 5% respectively).
  • Obesity (15.5%) was less prevalent among Asians and NHOPIs compared to non-Hispanic whites.
Implications

• This study found significant racial and ethnic social contextual differences among rural residents
  • Rural racial and ethnic minorities tended to be younger than non-Hispanic whites
  • Rural non-Hispanic blacks, Hispanics, and AI/ANs tended to be poorer and have lower educational attainment

• Developing and implementing future programs and policies to advance health equity in rural communities:
  • Increases understanding of the unique needs of each racial and ethnic population
  • Takes into consideration the variations in the social determinants of health within and among groups

Next Steps

• More research is needed to:
  • Understand the interaction between race and ethnicity and geography (i.e., regional, state, and local influences)
  • Assessing racial and ethnic disparities within rural communities
  • Monitoring how changing demographics are influencing health disparities among new and growing populations
Thank you


https://www.cdc.gov/mmwr/volumes/66/ss/ss6623a1.htm

DISCLAIMER: The findings and conclusions in this presentation are those of the authors and do not necessarily represent the official position of either the Centers for Medicare & Medicaid Services or the Centers for Disease Control and Prevention.
OUR AREA

BLYTHE CA IS CONSIDERED UNDER THE HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) AND SERVES THE MINORITY WHO ARE ENROLLED IN MEDI-CAL SERVICES. ACCORDING TO THE 2015 U.S. CENSUS, BLYTHE IS 23.2% BELOW THE NATIONAL POVERTY LEVEL AND TO INCLUDE, 16.6% ARE WITHOUT INSURANCE.

IN ADDITION

Of the nearly 19 million patients currently served through these HRSA-funded health centers, 63 percent are racial and ethnic minorities and 92 percent are below the federal poverty level.

FURTHERMORE

There was a gap identified with the Palo Verde Children’s Outreach HRSA Diabetes Grant; out of every 10 students 6 were considered obese and/or over the 95th percentile for K-6th grade school aged children. (The dominant population was Hispanic).

HEALTH DISPARITIES AMONG RACIAL AND ETHNIC MINORITIES WITHIN RURAL AREAS

Needs:

- Lack of access to care
- Need for economic development
- Need specialty care
- Medi-Cal & healthcare services for the minority
CONNECTING THE DOTS... WHOLE PERSON CARE

- Community Outreach (Parent/Community Support)
- Building Partnerships/Consortium Team Building (Investors, Stakeholders-Riverside County, Local Supports)
- Utilizing All Resources (Educators, Volunteers, etc.)
- Education (Bienestar, BuenaVida, SPARKS) & Training (Promotoras-Community Health Workers, Parents, Teachers and Students)

| Chronic Collaborative Care Coordination for high risk population |
| A1c Monitoring, BMI Calculation, PhQ2/9, SBRT, Training of symptoms of depression/suicide |
| E.H.R., Data analytics for sustainability Integration of Physical and Behavioral |

ADDRESSING MULTIPLE HEALTH DISPARITIES FOR MINORITIES WITHIN RURAL COMMUNITIES

- Diabetes & Depression Education/Awareness
- Substance Abuse
- Annual Wellness
- PhQ-2/9, training of symptoms of suicide/depression
PVHD Goals:
1. Transform and strengthen health care reform within minority groups
2. Integrate a whole person care with warm hand-offs in multiple settings.
3. Reduce the recidivism of high utilizers for established reduction in healthcare cost by promoting health awareness and education.
4. Establish sustainability with EHR, building Partnerships (Medi-Cal, TCPI-ACA, HRSA) and data collection.
5. Inpatient and outpatient care coordination w/neighborhood private practices.
6. Access to a CM-clinical health coach, reduce readmissions, lower A1c, physical and behavioral health integration.
7. Health education, community outreach & care coordination, staff training and developments.
8. 5150 de-escalation drop-in center in collaboration with RCMH, community health collaboration.
9. EHR value-based payment (templates & billing/coding) tools, capturing of data analytics and interface (EHRs) to support transformation efforts for best practice and patient quality care in whole person and warm hand offs.
ACHIEVEMENTS

PALO VERDE HOSPITAL HAS BRIDGED THE GAP AND INTERTWINED HEALTHCARE DELIVERY WITH RIVERSIDE COUNTY

New Drop In Center For The Mental Health Population at Palo Verde Hospital.

(Medi-2020) Connecting The Dots: Hybrid Integrated Whole Person Healthcare Reform
Liz Manjarrez, Sandra Anaya, Christa Rohde, Megan Allen, and Nemmir Salem,

PALO VERDE HOSPITAL DISTRICT

Introduction

Palm Springs, CA: In 2020 is to bridge the whole person gap by connecting the dots, this will lead to the transformation of a ‘Whole Person Care’ leading to a ‘Whole Person Health’ transformation. This transformation will occur in phases, starting with phase one.

With Riverside County, Riverside County Department of Mental Health, Riverside County Department of Public Health and Riverside County Department of Health and Human Services, we will build a whole healthcare transition program, in addition to developing partnerships of patient care in each area.

As a result of this transformation, the first phase of a whole person healthcare system will emerge.

Identifying The Gap

Since 2011, the PRIME has been in place at the Riverside County, and the PRIME Program received the following: Direct care services are still a gap in healthcare services; lack of clinical assessment, care coordination, integrated health and behavioral health services; lack of data collection; and lack of data driven techniques to test products and whole person care.

Building bridges and collaboration partnerships are needed to eliminate or reduce the gap.

Transition & Implementations

The transition and implementation of the PRIME Project Multi-Cultural, Multisite PRIME (with the support of Riverside County, and Riverside County Department of Health and Human Services) is required.

The goal is to increase the capabilities to practice a hybrid integrated care approach that integrates Whole Person Health and Whole Person Healthcare.

Palo Verde Hospital District and its partnerships healthcare implementation, through PRIME will be focused on serving the patients, primary care, and medical specialists who care for patients.

Stratification includes patients, critical patients, and critical care.

Results

The PRIME Project Multi-Cultural, Multisite PRIME (with the support of Riverside County, and Riverside County Department of Health and Human Services) is required.

The goal is to increase the capabilities to practice a hybrid integrated care approach that integrates Whole Person Health and Whole Person Healthcare.

Results are measured through various methods.

Conclusion

The PRIME Project Multi-Cultural, Multisite PRIME (with the support of Riverside County, and Riverside County Department of Health and Human Services) is required.

The goal is to increase the capabilities to practice a hybrid integrated care approach that integrates Whole Person Health and Whole Person Healthcare.

Results are measured through various methods.

(PALO VERDE HOSPITAL DISTRICT)
Building Tomorrow’s Smiles Too

Linda Matessino, RN, MPH
• Grant Projects Manager

Innis Community Health Center Inc.
• FQHC with 3 primary sites & 2 School based Health Centers, 1 Fixed based dental & 1 Mobile dental Unit
• Innis, LA – Pointe Coupee Parish in southern Louisiana
• Consortium of 4 other FQHCs operating 5 SBHCs in other rural LA parishes (counties)

Demographics of Areas Served

• Higher incidence of dental caries in rural populations.
• Additionally, in 2010 (nationally) only 40% of children on Medicaid received dental services. In LA it is reported 38%
• All areas in this project are designated:
  – Medically Underserved Areas (MUA)
  – Health Professional Shortage Areas (HPSA)
• Have significant geographic barriers to access to care
• Louisiana has significant oral health statistics
  – 6th highest % of 3rd grade students in the nation with caries experience (treated or untreated tooth decay) - 65.7%
  – 2nd highest % for untreated tooth decay at 41.9%. (CDC report)
Demographics cont’d

• Target areas have a higher % of minorities than does the state or country.

• 3 target parishes and surrounding areas are ranked among the **lowest** in the state and the nation in per capita income

• All 5 parishes have a higher unemployment rate than the US. The average –7.6% (State-6%)(National-4.9%)

• Additionally, the combined % of at-risk students (e.g. eligible for free or reduced lunch) is **77.9%** (2014) compared to **67%** for the state (2014) and **47.5%** US (2013).

Demographics cont’d

• **Poverty** is a barrier to healthcare in Louisiana.

• Poor, **lower socioeconomic** groups and African Americans are less likely to receive dental care (Rural Healthy People 2010 Report on Oral Health).

• Target area- has high rates of poverty, a large number of African American children, and is located in rural areas where access to care is a challenge and a distinct disparity.

• The **Race** demographics in the area-
  - 61% Cauc  < 4% Other
  - 35% AA
Building Tomorrow’s Smiles Too
History of Grants

2009-2012: 3 year grant whereby primary care providers & staff trained to provide oral health screenings + fluoride varnish during well-child visits in primary care settings of 3 FQHCs.

2012-2015: 3 yr. grant with shift in access focus to School-Based Health Centers (SBHCs) as Portal of Access operated by rural FQHCs. Goal was Access to kids

2015-2018: Expanded into additional SBHCs and added dental case management for referrals.
Building Tomorrow’s Smiles Too

Approach

• **Who**: School-aged children
• **Where**: FQHCs with SBHCs
• **How**: Integrating oral health screening and prevention into primary care, with...
  - Oral health screening within comprehensive physical exam
  - Application of Fluoride varnish (evidence-based to dental caries)
  - Referral to “dental home” for follow-up care (best practice)
  - Dental Case management (best practice)

FACTS —ACCESS DISPARITIES

CHILDREN AT HIGHER RISK OF POOR ORAL HEALTH ARE:

- CHILDREN IN FAMILIES –LOW SOCIOECONOMIC STATUS
- CHILDREN WITH LOW UTILIZATION OF DENTAL SERVICES
- CHILDREN OF RACIAL AND ETHNIC ORIGINS- African Americans, Hispanics, American Indians, and other racial minority groups have disproportionate burden of disease.
- CHILDREN WHO ARE PUBLICALLY INSURED
Facts: Disparities cont’d

• A disparity in dental caries exists across socioeconomic and geographic sub-groups in the population.

• In children of mothers with a high caries rate, especially untreated caries.

• Significant racial/ethnic disparities in oral health among children + adults in US.

• AA adults are more likely to report tooth pain, tooth decay, loose teeth, and to have lost more teeth than Cauc adults.

• AA are less likely than Cauc adults to have visited a dentist in the past year.

Oral Health Care-Disparity

• Rural Healthy People 2010 survey reports oral health ranked 5th in need among the 28 focus areas.

• Healthy People 2020 initiative contains over 1,200 objectives that serve as a roadmap for tracking the nation’s health.

• Oral health is 1 of 42 Healthy People topic areas comprising 33 objectives ranging from dental caries, periodontal disease, to access to preventive dental services and program infrastructure.
Barriers to Care-Faced by Families

**Internal**
- Parents belief systems & practices anxiety & phobias
- Low parental literacy & understanding
- Lack of parental knowledge re: optimal oral health & prevention
- Home oral care practices viewed as time consuming when compared to other responsibilities.

**External**
- Difficulty locating providers who will take Medicaid pts.
- Lack of health insurance coverage
- Lack of transportation
- Having to miss work to take kids to dentist
- Limited dental hrs to schedule appts.

**Statistics : Yrs. 1 & 2**

- Total Oral Health Assessments - 3986
  - AA – 64%  
  - Cauc - 33%
- Total Flouride Varnish applications - 3173
- Total Referrals (Preventive & Problematic) – 1511
- Total referrals not seen – 51% - Barriers here
Building Tomorrow’s Smiles Too

Contact Information:
Linda Matessino, RN, MPH
Grant Projects Manager
Innis Community Health Center
6450 LA. Hwy 1
Innis, LA 70747
225-921-5196
Linda@inchc.org

Thank You!

Questions?

ruralhealthinfo.org
Thank you!

- Contact us at ruralhealthinfo.org with any questions
- Please complete webinar survey
- Recording and transcript will be available on RHIIhub website