HCA
HOME CARE ASSOCIATION
OF NEW YORK STATE

Home Care: A Major Partner for Tackling Health Disparities

New York's home care providers are perfectly positioned to meaningfully contribute to the goal of achieving health equity.

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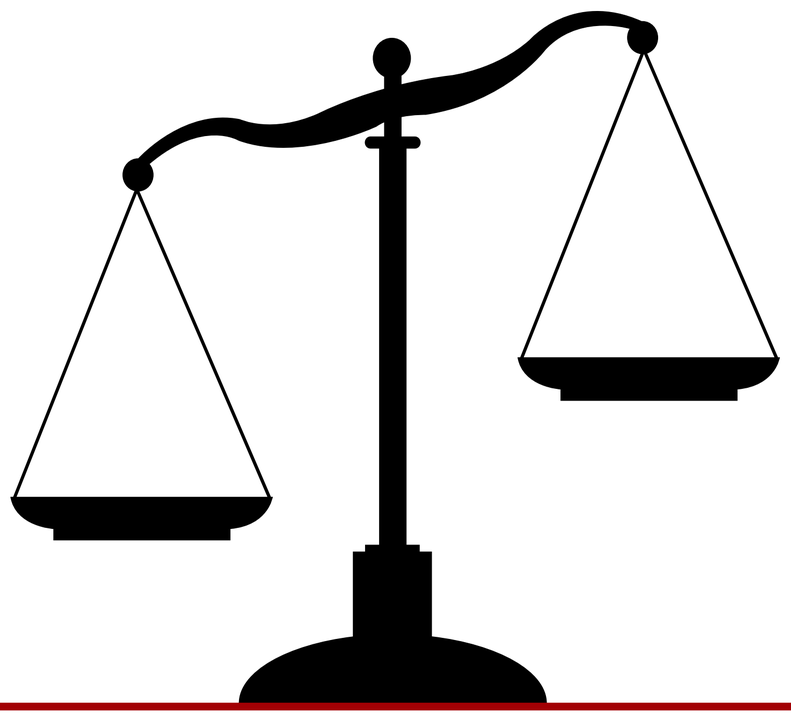
Health Disparities

are differences in health outcomes and their causes among groups of people.

These disparities adversely affect ‘groups of people who have systematically experienced greater obstacles to health care based on their racial or ethnic group; cultural or linguistic factors; 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 [7].'

Disparities emerge when some groups of people have less access to or engagement with opportunities and resources over their their lifetime and across generations [7].



Health Equity

is when everyone has the opportunity to be as healthy as possible.

Achieving health equity means reducing and ultimately eliminating unjust and avoidable differences in health, conditions, and resources needed for optimal health by improving the health of marginalized groups, not by worsening the health of others [7].

The choices we make typically depend on the opportunities we have, such as quality education, access to healthy foods, and living in safe, affordable housing but these opportunities are not the same for everyone [7].

Home care Providers

are well-positioned to provide culturally competent and person-center interventions that are viable and effective in addressing health disparities across NYS.

Why do Health Disparities Matter?

Disparities not only severely affect the health of individuals within groups, resulting in higher rates of illness, preventable conditions, premature death and enormous avoidable costs, but also limit overall gains in quality of care and health for the broader population [7].

Conditions known as the 'social determinants of health,' such as lack of access to good jobs, living in unsafe neighborhoods, and lack of safe transportation, are factors that impact our health. If not addressed, these can fuel health disparities [10].

In 2016, the Office of Minority Health under the U.S. Department of Health and Human Services reported that medical expenses from preventable illness related health disparities were equal to $50.3 billion [11].

Groups with difficultly and/or instability with one or many social determinants experience delays and other obstacles in care and less favorable health outcomes and improvement measures. This is because transportation issues, language or cultural barriers, and other social factors make people less likely to get the preventative care they need to stay healthy, more likely to suffer from serious illness, such as diabetes or heart disease, and less likely to engage or have access to quality health care when they get sick [10].

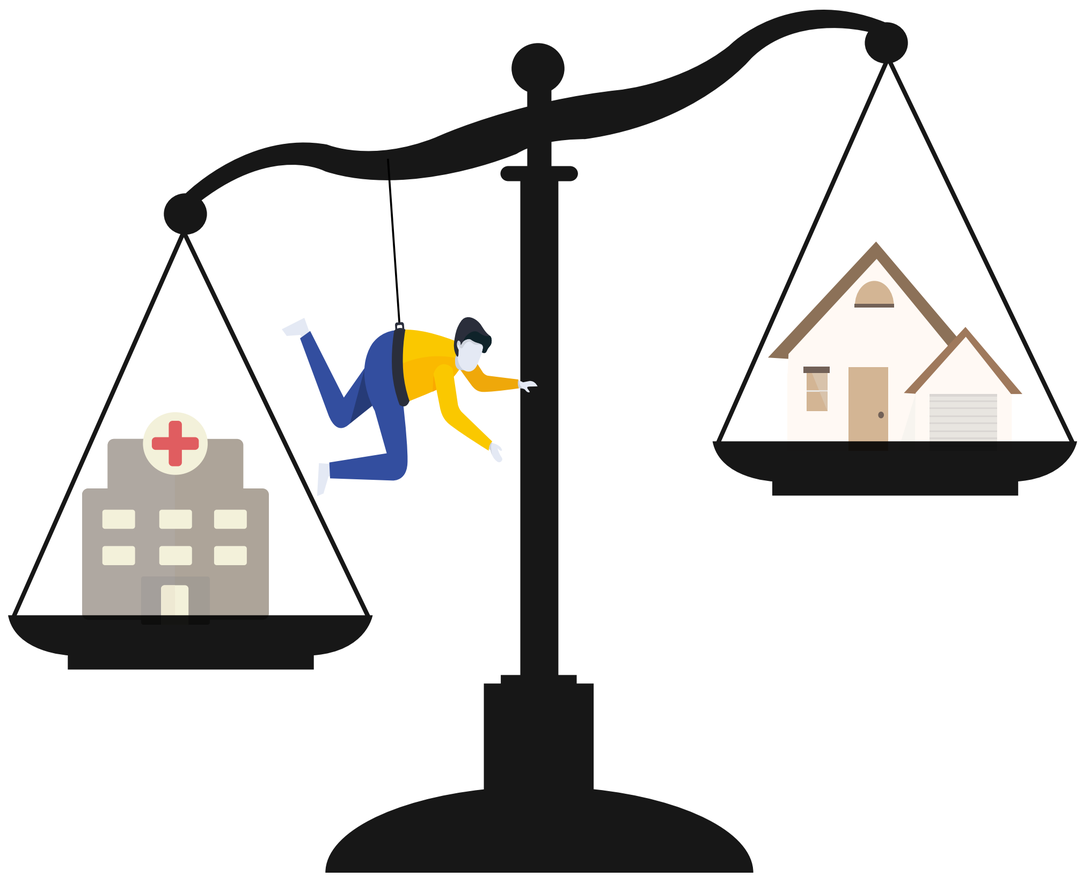
Collaborative Home Care Interventions to Address Health Disparities

It is imperative for New York to address barriers that impede collaboration of health care providers and capitalize on collaborative opportunities that harness all parts of the continuum for disparity intervention.

Ensuring that health care is culturally and linguistically competent, accessible and available to all are keys to reducing health and health care disparities [2].

On December 17, 2017 the New York State Department of Health issued a Dear Administrator Letter (DAL) authorizing the creation of Hospital-Home Care-Physician Collaborative Law. This DAL facilitates collaborative innovation through integrated care models and provides a framework for providers to improve:

- Patient care access
- Patient health outcomes
- Cost-effectiveness in the use of health care services; and
- Community population health



"Of all forms of inequality, injustice in health care is the most shocking and inhumane."

Dr. Martin Luther King

The Unique Position of Home Care Providers to Address Disparities

Home care is uniquely positioned as a model and a service to address disparities. Fundamental to home care is its consideration of and focus on the entirety of the patient's circumstances - including social determinants of health - in assessing, planning and delivering care.

Home care works within the patient's individual, personal and cultural needs and surroundings. Home care workers enter a patient's home, day-to-day personal life and, in many cases, become an integral part of the family.

Within the patient's overall network of providers, home care is often the vehicle of regular connection and feedback to the person's physician and other care providers, as well as the facilitating intervention and ongoing process of care management.

Home care providers work toward recruitment and placement of culturally and linguistically competent staff. Throughout New York State, home care providers offer special care training and assignment, including special language training in Russian, Chinese, Italian, Haitian, and many others.

Home care providers also incorporate specialty programs and tools, like telehealth for addressing specific conditions that are prone to treatment disparities, including: diabetes, asthma, hypertension, cardiovascular disease, mental health, maternal and child health, sickle cell, HIV/AIDS, and other [12].

Home Care Delivers the Triple Aim

- Better health and access
- Better health care experience
- Lower costs related to care
- Better integration of home care into collaborative models, designed to reduce health disparities, will sustain and accelerate the narrowing of the gaps related to access, engagement, cost and experience with health care services.

Culture-based Home Care Model

- Assessing patients through a cultural lens, promoting competent care / components of an evidence-based cultural assessment.
- Recruitment of a diverse nursing, therapy, social work and home health aide workforce that mirrors the diversity of the patients and community being served.
- Care planning and delivery is also adapted to meet the needs of an individual's cultural preference.
- Provision of culturally and ethnically aligned care in the home, in the intimate aspects of the family and patient's social structure.
- Engage with culturally compatible partners within the local community.
- Utilizing a culturally driven menu planning for diabetic and heart healthy diets.
- Education materials which align with cultural beliefs, characteristics, and preferences of the patient and/or community.
- Effective patient-centered and culturally informed advocacy [12]

Home Care Legislation Related to Health Disparities

HCA has developed legislation that would allow the aforementioned collaborative teams to develop and implement models specifically targeting health disparities over a range of conditions, including those described in this paper.

This HCA legislation introduces an integrated model which aligns participating providers with a mission of eliminating health disparities. In creating the models, these partners could further incorporate key social and cultural organization resources related to the particular conditions and affected populations. The model would extend to all areas of major health need (acute, emergency, primary, home based), and in the case of home care, offer culturally competent services and support directly in the neighborhoods and homes of individuals.

This integrated, person-centered approach, would help transcend barriers of fragmented care and address barriers and challenges related to:

- Language
- Fear and avoidance of the health system
- Culture and ethnicity
- Rural areas and other geographic areas where there is dearth of resources to meet community's needs
- Family and home education
- Transportation and access; and
- Many other obstacles or sources of resistance that contribute to disparity

Home care uniquely brings care to the patient, into their home, family, community, neighborhood. As such, is a powerful partner for making culturally and person-centered intervention all the more viable and effective in NYS.

HCA believes that legislative, fiscal and policy support of such a model carries a huge return on state/federal/insurer investment on behalf of critical individual and population health improvement, health equity, and major health care cost avoidance in acute, emergent, and long term health care.

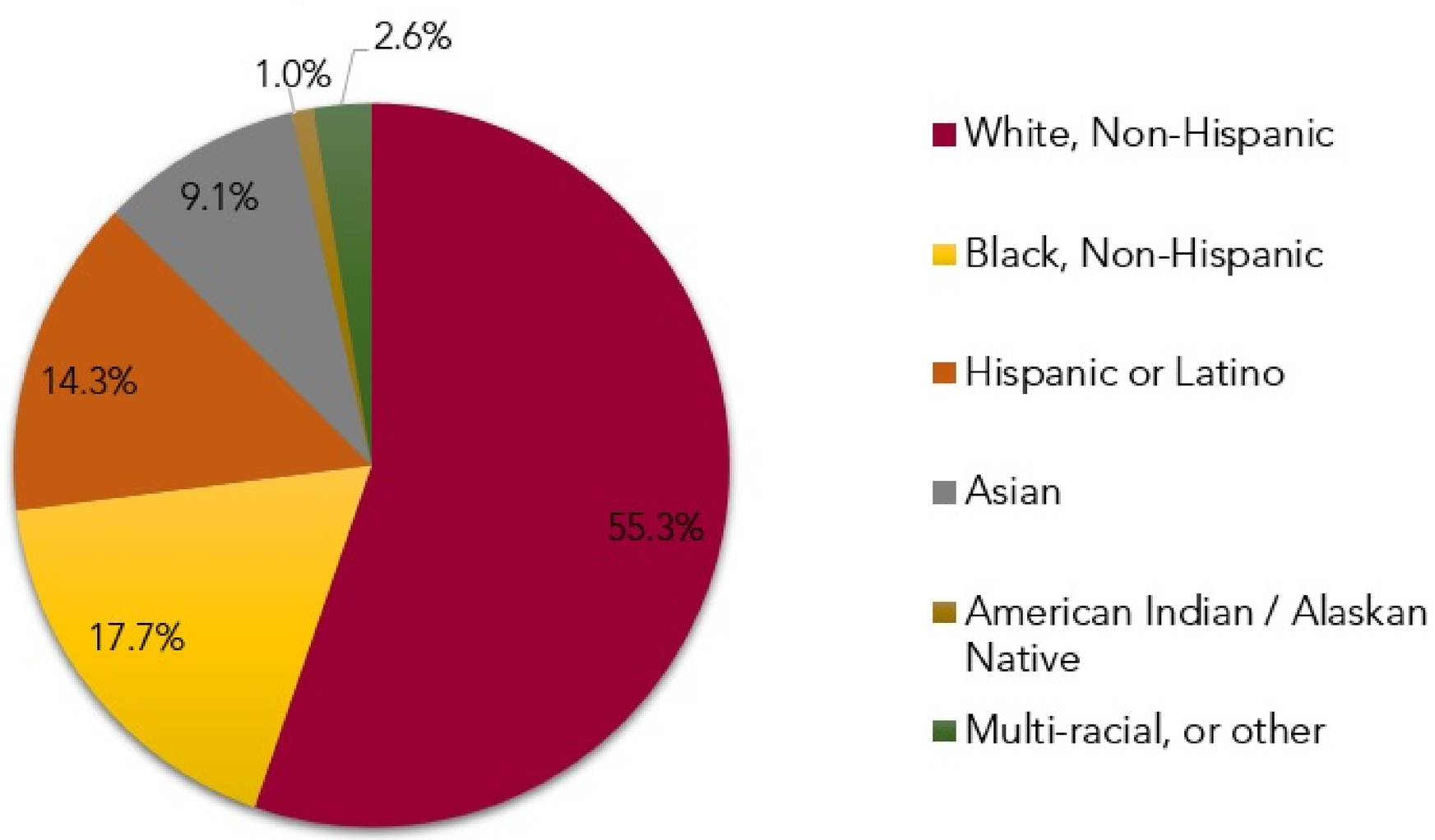
HCA urges state and federal health care leaders to consider such collaborative home care and partner models for addressing health disparities among our residents in a way that is innovative and person-centered.

Consider what the continuum of care providers, including home and community based care, can do.

New York State
Population & Demographics

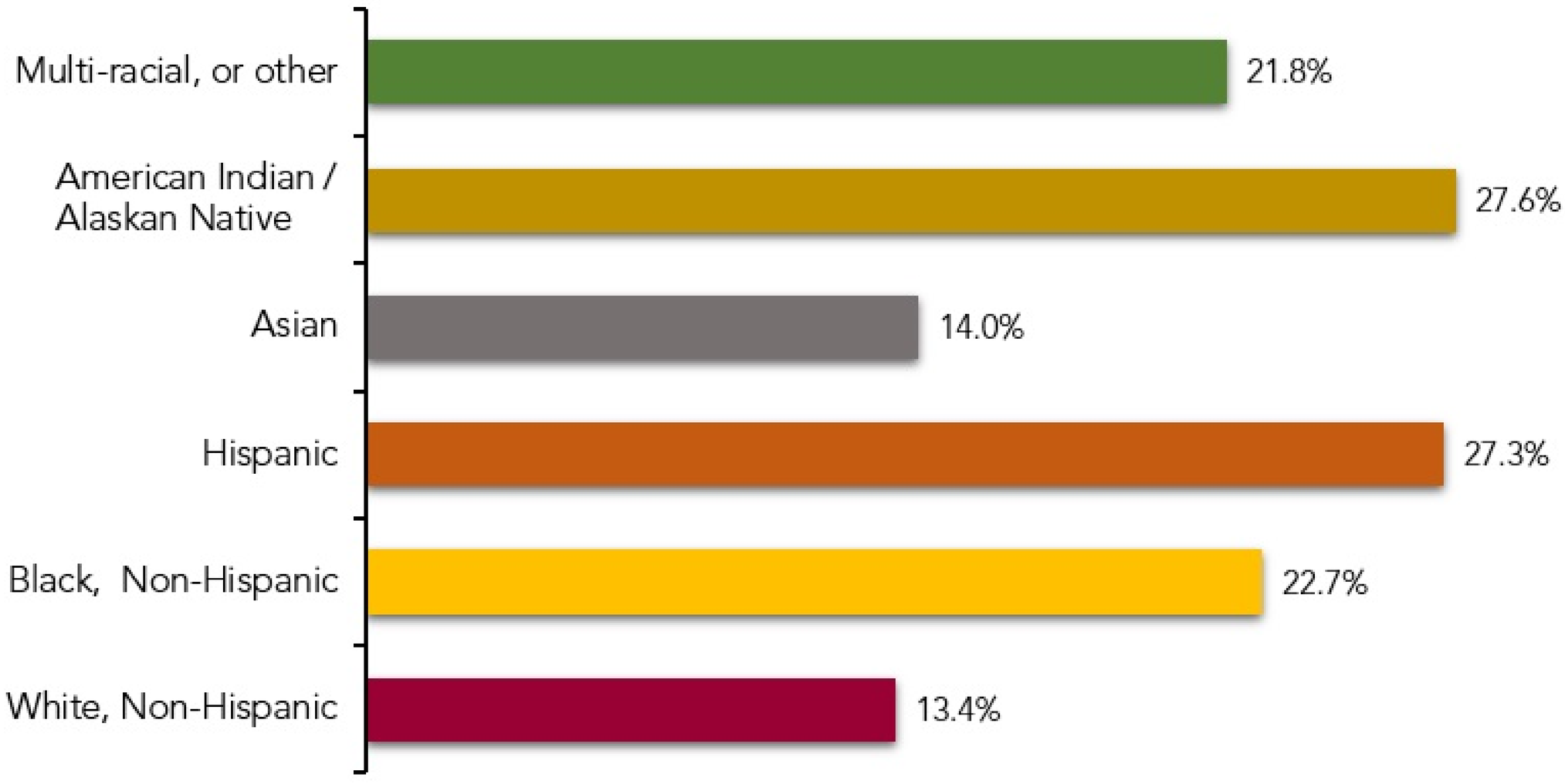
Throughout New York State, many groups are disproportionately at risk of being uninsured, lacking access to care, and experiencing worse health outcomes compared to people with higher incomes and easier access to health care and services [1].

Estimated Population of New York State in 2018



Source: https://www.census.gov/quickfacts/fact/table/ny/PST045218#qf-headnote-a

Percentage of NYS Population Who Reported 'Fair or Poor' Health Status in 2017



Source: Center for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Prevelance & Trends Data for 2017

Prevalence of Chronic Conditions & Health Disparities

Some groups in the United State and throughout NYS are at higher risk for illness and experience poorer health outcomes compared to other groups. According to the Center for Disease Control and Prevention's (CDC) 2013 report on U.S. health disparities, the major areas of starkly uneven health outcomes include:

- Blacks and American Indians and Alaska Natives are more likely than Whites to report a range of health conditions, including asthma, diabetes, and heart disease.

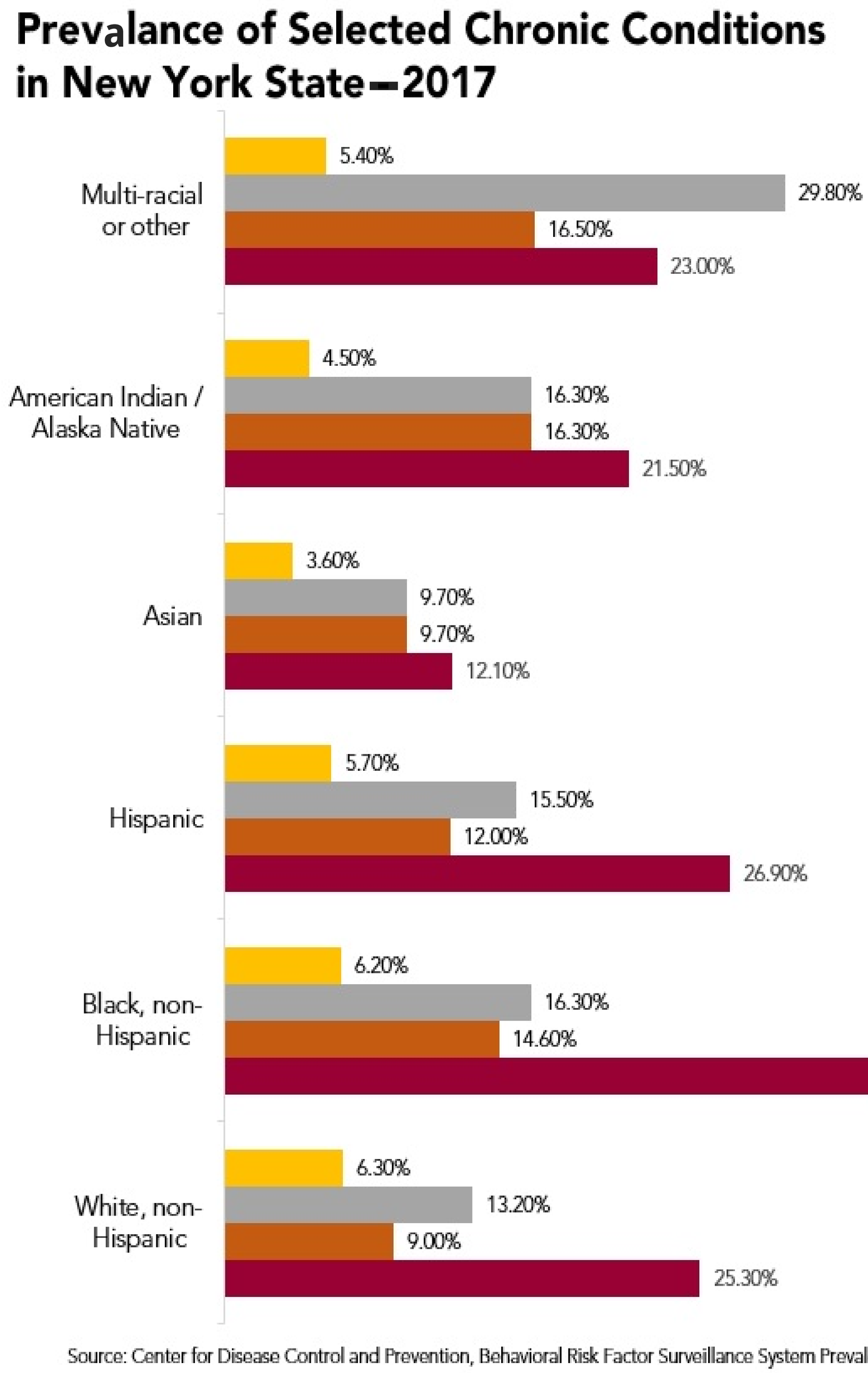
- Adult diabetes is more prevalent among Hispanics and non-Hispanic Blacks than among Asians and non-Hispanic Whites, and also more common among adults who don't have a college degree or come from a lower-income household.

- Infant mortality rates are more than twice as high for non-Hispanic Blacks compared to non-Hispanic Whites.

- Strikingly, Blacks experience rates of HIV and AIDS that are 8 and 10 times higher than Whites.

- Low-income people of all races report worse health status than higher income individuals.

- Research also suggests that some subgroups of the LGBT community have more chronic conditions as well as higher prevalence of disabilities than heterosexuals.



* Cardiovascular Disease includes coronary heart disease, angina, myocardial infarction, and stroke.

Source: Center for Disease Control and Prevention, Behavioral Risk Factor Surveillance System Prevalence & Trends

Obesity

Obesity is currently the second leading cause of preventable death in the United States.

By the year 2050, obesity is predicted to shorten life expectancy in the U.S by 2.5 years and is a risk factor for many chronic diseases and conditions including:
type 2 diabetes, asthma, high blood pressure, high cholesterol, stroke, heart disease, certain types of cancers, and osteoarthritis [4].

8.5 million
individuals are either obese or overweight in NYS.

- The prevalence of obesity in NYS is highest among Black, non-Hispanic adults at 35.3% and Hispanic adults at 26.9% adults.
- Hispanic children have the highest prevalence of obesity - 18.1% compared to 12.7% of Blacks and 11.9% of whites.
- 30.5% of individuals who earn an annual household income less than $25,000 and 38.1% of individuals living with a disability are either obese or overweight.
- The prevalence of obesity is less among those with a college degree [4].

Diabetes

Diabetes is a chronic disease in which blood sugar (glucose) levels are above normal. Typically, cells in the body access the energy stored in glucose, a form of sugar created from digestion of food, through a chemical process involving the hormone insulin.
In a person with diabetes, this process is impaired.

In Type 1 diabetes, the pancreas fails to produce insulin and in those with Type 2 diabetes, the cells of the body become resistant to insulin. Type 2 accounts for about 90-95% of all diagnosed cases of diabetes, while Type 1 accounts for about 5% [4].

1.6 million
adults have been diagnosed with diabetes in NYS.

- 14.60% of Black, non-Hispanic adults and 12% of Hispanic adults are diagnosed with diabetes in NYS, compared to only 8.8% of non-Hispanic White adults.
- Hispanic adults have a death rate from diabetes that is 40% higher than non-Hispanic Whites' death rate.
- 19.4% of adults who are obese and 21% of individuals with a disability are diagnosed with diabetes.
- 20.8% of Medicare recipients and 12.8% of Medicaid recipients are diagnosed with diabetes - compared to only 7.1% of private insurance recipients.
- Native Hawaiians/Other Pacific Islanders are more than six times as likely to die from diabetes [4].

At the current rate, one in three American adults will develop diabetes in their life time.

Cardiovascular Disease

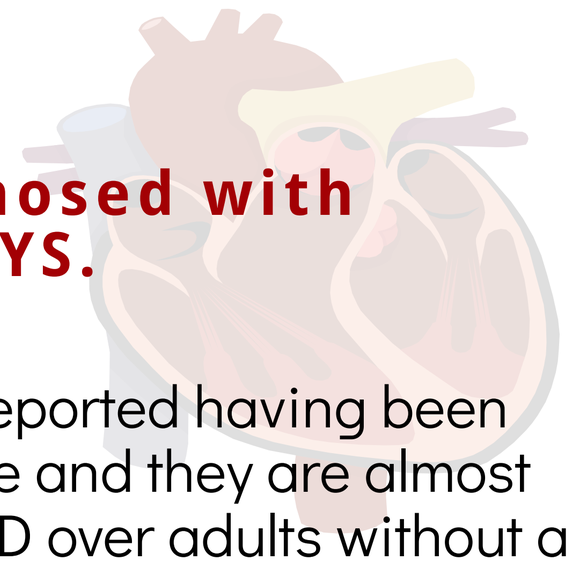
Cardiovascular Disease (CVD) is a group of diseases involving the circulatory system, including: heart attack, angina, coronary heart disease (CHD), and stroke.

CVD is the leading cause of death in New York State, accounting for almost 40 percent of all deaths statewide.

It is also the leading cause of preventable death in people less than 65 years of age [4].

1.14 million

individuals have been diagnosed with cardiovascular disease in NYS.



- 17.9% of adults living with a disability reported having been diagnosed with cardiovascular disease and they are almost four times more likely to experience CVD over adults without a disability.

- Black, non-Hispanic adults are 9% more likely to die from heart disease than white, non-Hispanic adults.

- In 2016, only 2 out of 5 adults in NYS recognized all five common signs and symptoms of a stroke correctly and 1/3 then called 9-1-1. Males and Hispanics were significantly less likely to be aware of signs and symptoms.

- American Indians / Alaska Natives are 60% more likely to have a stroke than New York Whites [4].

Asthma

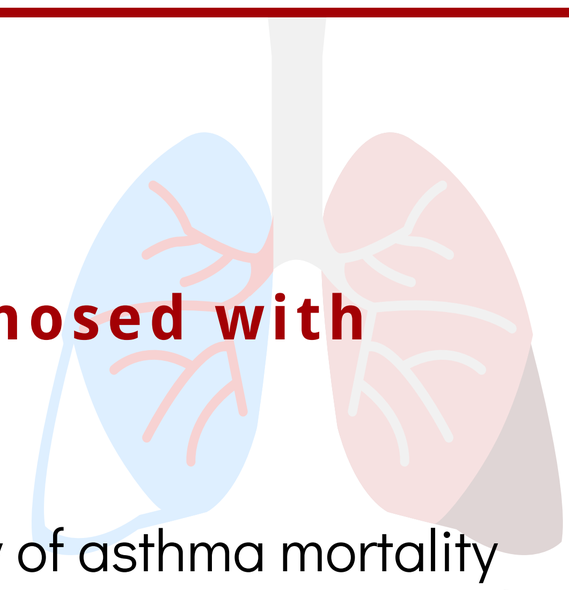
Asthma is a disease that affects the lungs. It is a chronic inflammatory disorder of the airways that causes repeated wheezing, breathlessness, chest tightness, and nighttime or early morning coughing.

Asthma can be controlled by following a medical management plan and by avoiding contact with environmental 'triggers,' such as cockroaches, dust mites, furry pets, mold, tobacco smoke, and certain chemicals.

Asthma remains a major public health concern, causing limitation of activity and costs the United States $56 billion in medical costs and lost school and work days [4].

1.9 million

individuals have been diagnosed with asthma in NYS.



- According to the CDC's 2015 summary of asthma mortality data, Black Americans have a higher asthma death rate of 23.9 deaths per million persons, compared to 8.4 deaths per million persons for non-Hispanic whites, and 7.3 deaths per million persons for Hispanics.

- In 2013, the total cost of asthma-related expenditures for all health care payers in NYS was $1.3 billion and $532.7 million of that were Medicaid dollars.

- In 2016, there were 152,00 emergency department visits and 20,000 hospitalizations due to asthma.

- Evidence shows that effective control of asthma requires eliminating triggers from the home [4].

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HCA
HOME CARE ASSOCIATION
OF NEW YORK STATE

Contact Information

For more information or details in relation to this report, please contact:

Lauren Ford
Director of Program Research,
Development and Policy
518.261.2540
lford@hcanys.org

Alfredo Cardillo
President and CEO
518.810.0663
acardillo@hcanys.org

Patrick Conole
Vice President for Finance and Management
518.810.0661
pconole@hcanys.org

Andrew Koski
Vice President for Program Policy and Service
518.810.0662
akoski@hcanys.org

Alyssa Lovelace
Director of Public Policy and Advocacy
518.810.0658
alovelace@hcanys.org

Roger Noyes
Director of Communications
518.810.0665
rnoyes@hcanys.org

Home Care Association of New York State
388 Broadway, Fourth Floor
Albany, NY 12207
518.426.8764
www.HCA-NYS.org