Advancing Health Equity in UCANR

A collaboration with UCSF School of Medicine, Department of Pediatrics, and Center for Child and Community Health.

UNIVERSITY OF CALIFORNIA
Agriculture and Natural Resources

UCSF
University of California
San Francisco

INTRODUCTION

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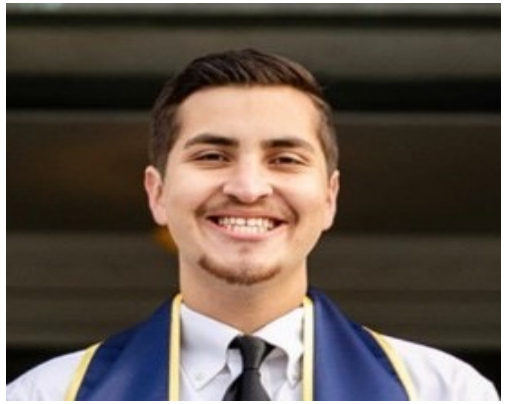


Oscar Ramos
Health Equity Intern

UCANR/UCSF: A powerful collaboration

Leveraging the strengths and expertise of UCANR and UCSF provides a potent and unique opportunity to bring these vital elements together with the goal of improving health in communities across California.

UCANR/UCSF: A powerful collaboration

- UCANR connects the power of UC research with local communities to improve the lives of all Californians.
- UCSF is part of the 10-campus University of California, and the only of its campuses dedicated to graduate and professional education specifically through a singular focus on health.

What is the overall goal of this webinar series?

To provide an interactive learning opportunity to come together and visualize how UC ANR can address critical health disparities we face and put into practice the opportunities outlined in UCANR's

Strategic Initiatives Health Equity Concept Note

Three-part webinar series goals:

1. Create **common language** around health equity

2. Identify how the work being done in UCANR fits in with UCANR and the Extension **health equity goals**

3. Inform **new areas and approaches** UCANR can work in to advance health equity in the future.

Today's Agenda

- 10 min intro slides
- 20 min definitions with examples using diabetes
- 5 min break
- 20 min case study
- 30 min for Jamboard activity based on case using the ecological framework or PSE.
- 5 min close and evaluation link

Who is in the Zoom?

BUILDING SHARED VOCABULARY

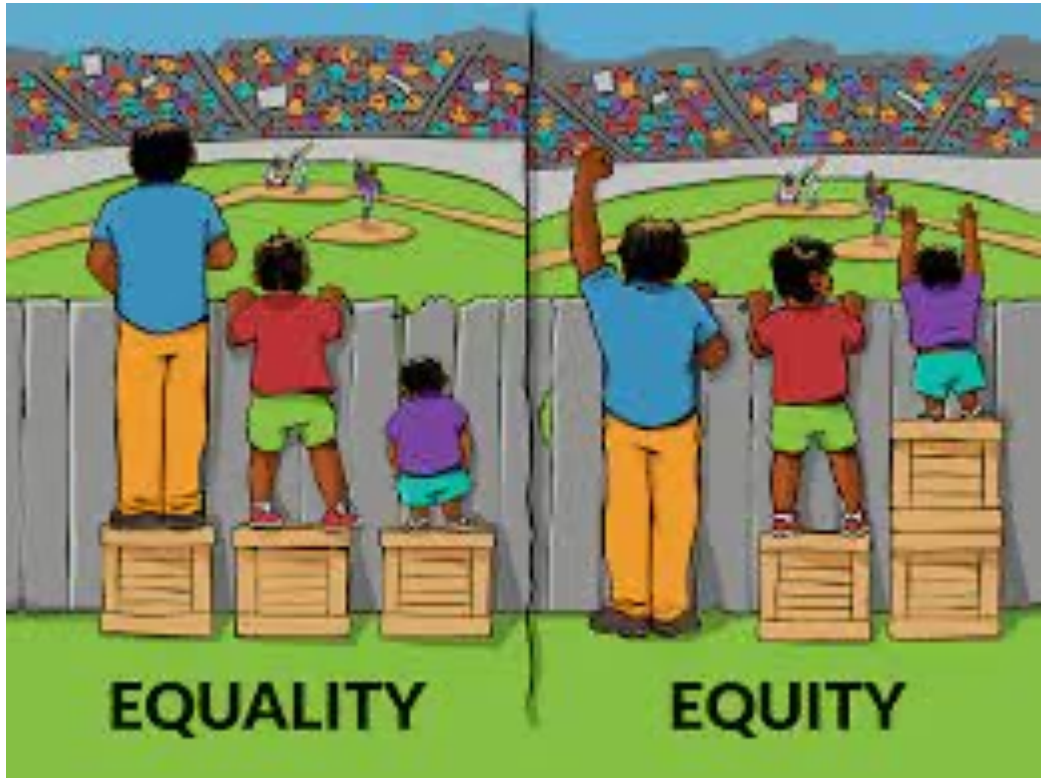
Equality ≠ Equity

Disparities = Differences in health amongst groups of people

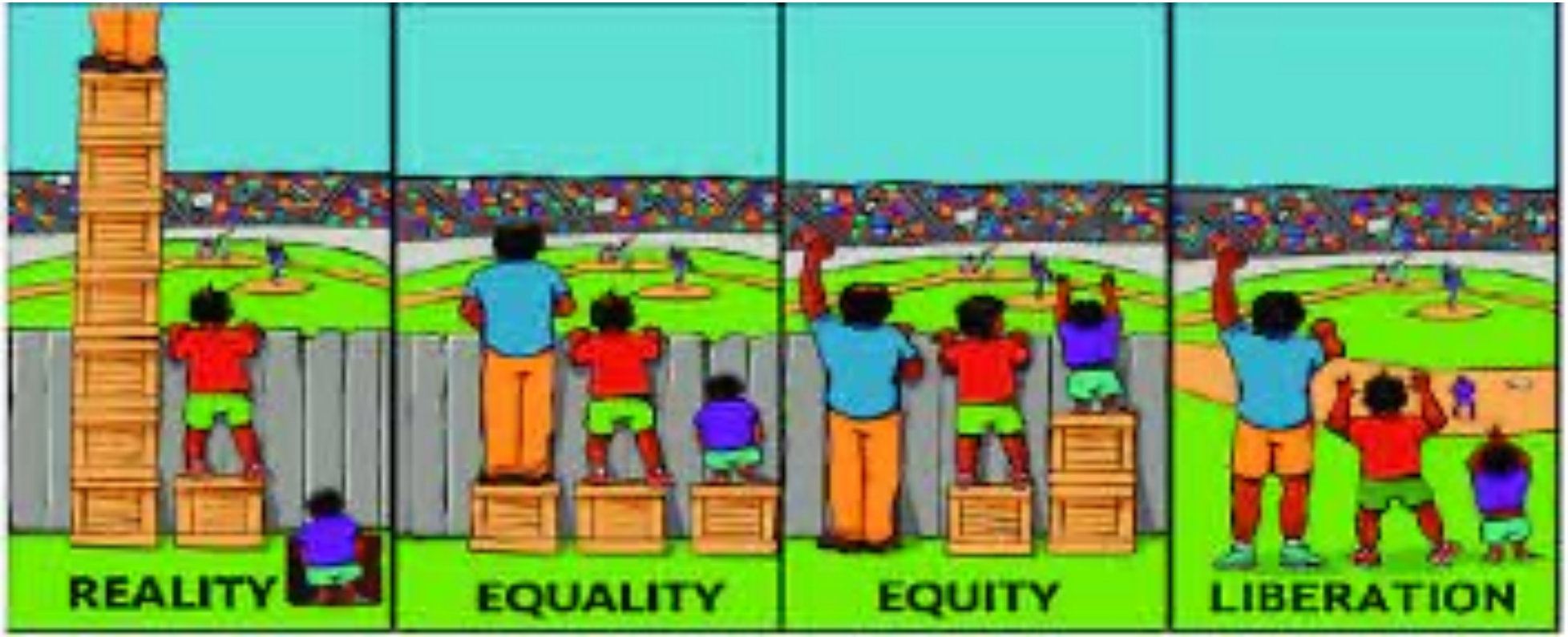
EQUALITY

EQUITY

Equity vs Equality: wrestling with ‘fairness’



A fuller picture…



Key Definitions:

- **Health Equity:** Everyone has a fair and just (equitable) chance to reach their best health.
  - CDC: everyone has the opportunity to attain their full health potential, and no one is disadvantaged in achieving this potential because of social or any other socially-defined circumstances
  - WHO: “the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification”

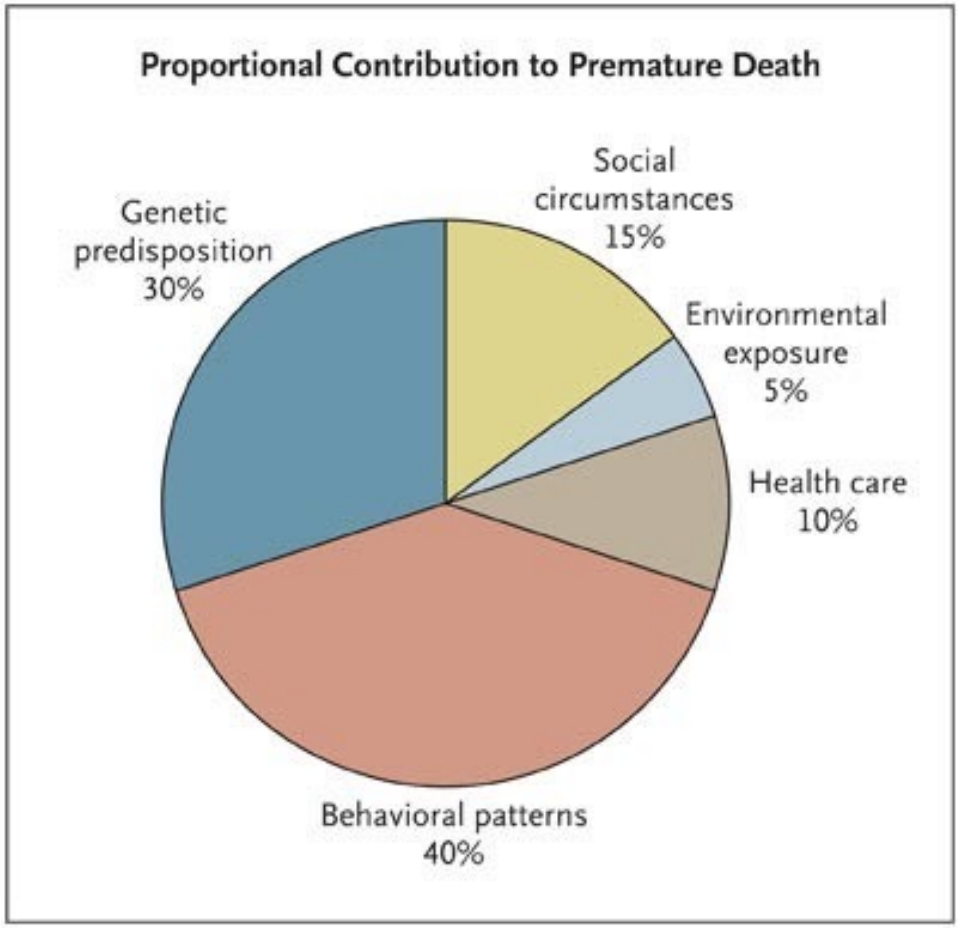
- **Health Inequities:** Potentially avoidable differences in health status between populations that are linked to social advantage and disadvantage

Key Definitions:

- **Health Care Equity:** Equitable access, experience and quality of care for populations of patients

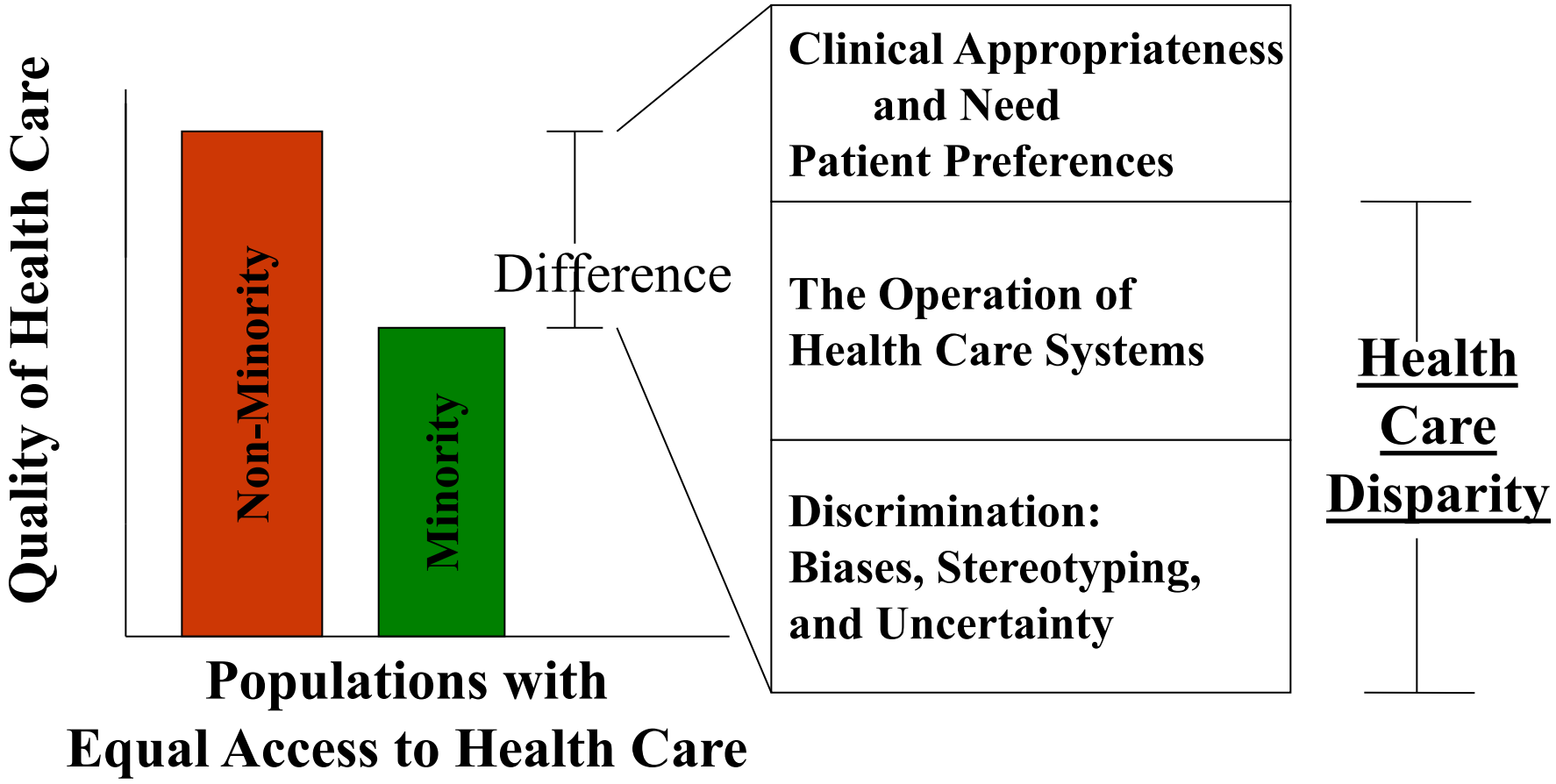
- **Health Care Disparities:** Difference is access, process and quality of care that disadvantage a population and are not attributable to clinical needs, patient preferences or appropriateness of an intervention

How does healthcare quality fit in?



- SDH create population patterns of health and disease
- Healthcare access and quality matter most once people are ill
- Healthcare disparities are problems of healthcare quality

What Explains Health Care Disparities?



Unequal Treatment, 2003

Drivers of Health

Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes
Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
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Figure 1: Social Determinants of Health

- Social Determinant of Health AKA
- Social Drivers of Health
- Impact populations and individuals

Drivers of Health and Structural Racism

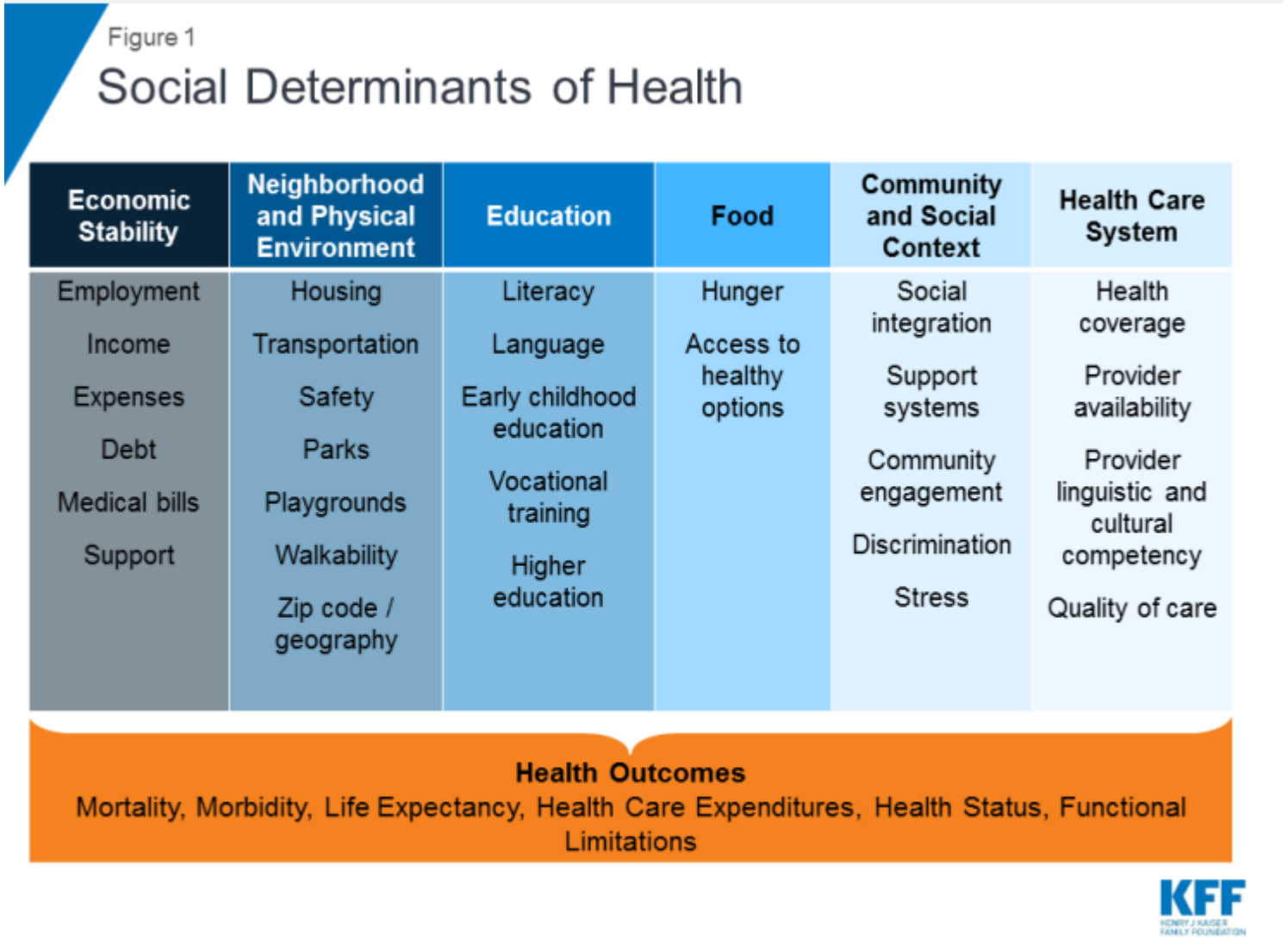
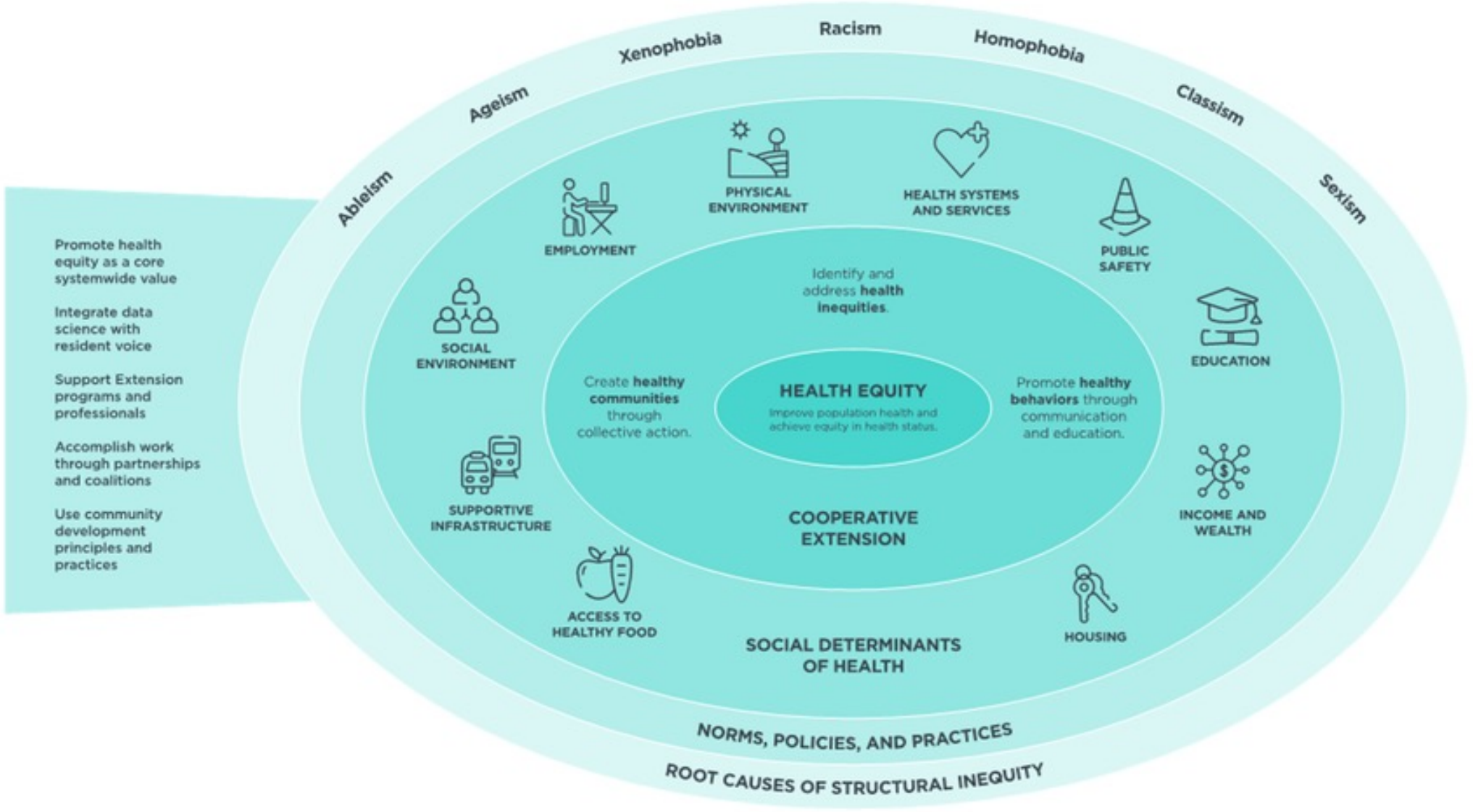


Figure 1: Social Determinants of Health

Structural racism impacts all drivers of health inequities on multiple levels

Cooperative Extension's National Framework for Health Equity and Well-Being



Comments, Clarifications, Questions?

Break time!
5min

CASE STUDY: DIABETES

Type 2 Diabetes

- Chronic disease, usually lifelong
- Interplay between environment, ‘lifestyle’, genetics.
- Typically managed by combination of medications, dietary changes and exercise

Consequences of poorly controlled diabetes

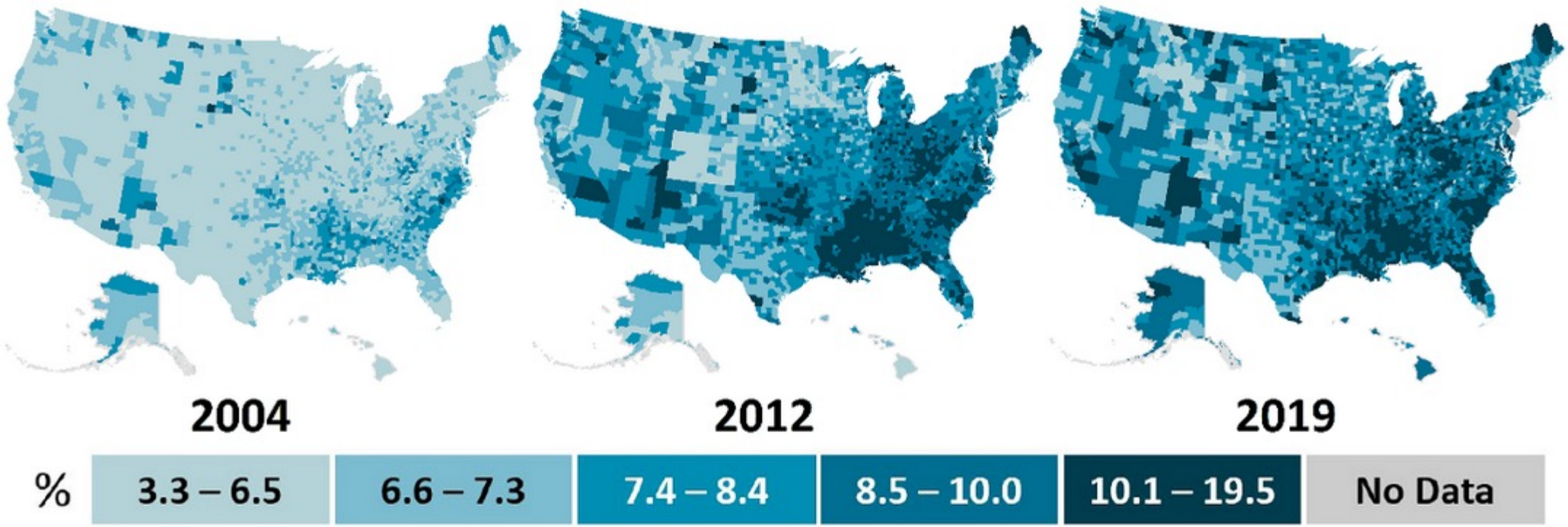
- Leading cause of
  - new blindness
  - kidney disease
  - amputation
- Heart disease and stroke

- 7th leading cause of direct death in US adults
- In 2017, annual direct costs estimated at $237 Billion. Indirect costs $90 billion

- CA: Over 3,200,000 people with diabetes 33% of adults about 12% of population

- CA: 33.4% of adults have pre-diabetes

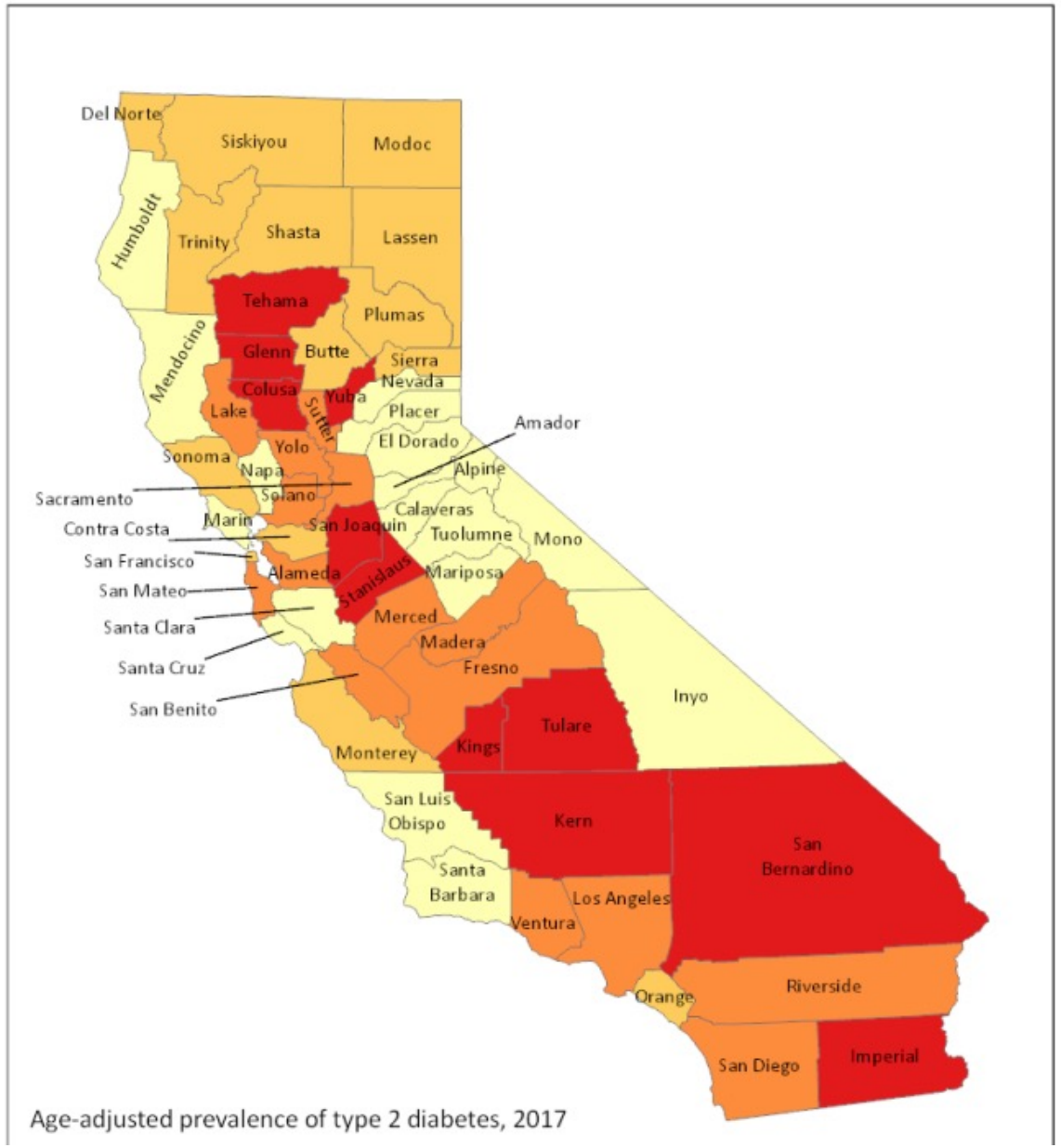
Figure 3. Age-adjusted, county-level prevalence of diagnosed diabetes among adults aged 20 years or older, United States, 2004, 2012, and 2019



Data sources: US Diabetes Surveillance System; Behavioral Risk Factor Surveillance System.

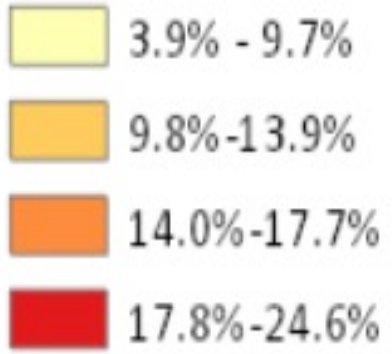
https://www.cdc.gov/diabetes/data/statistics-report/diagnosed-diabetes.html

Figure 2. Estimated age-adjusted prevalence of type 2 diabetes in California by county, 2017



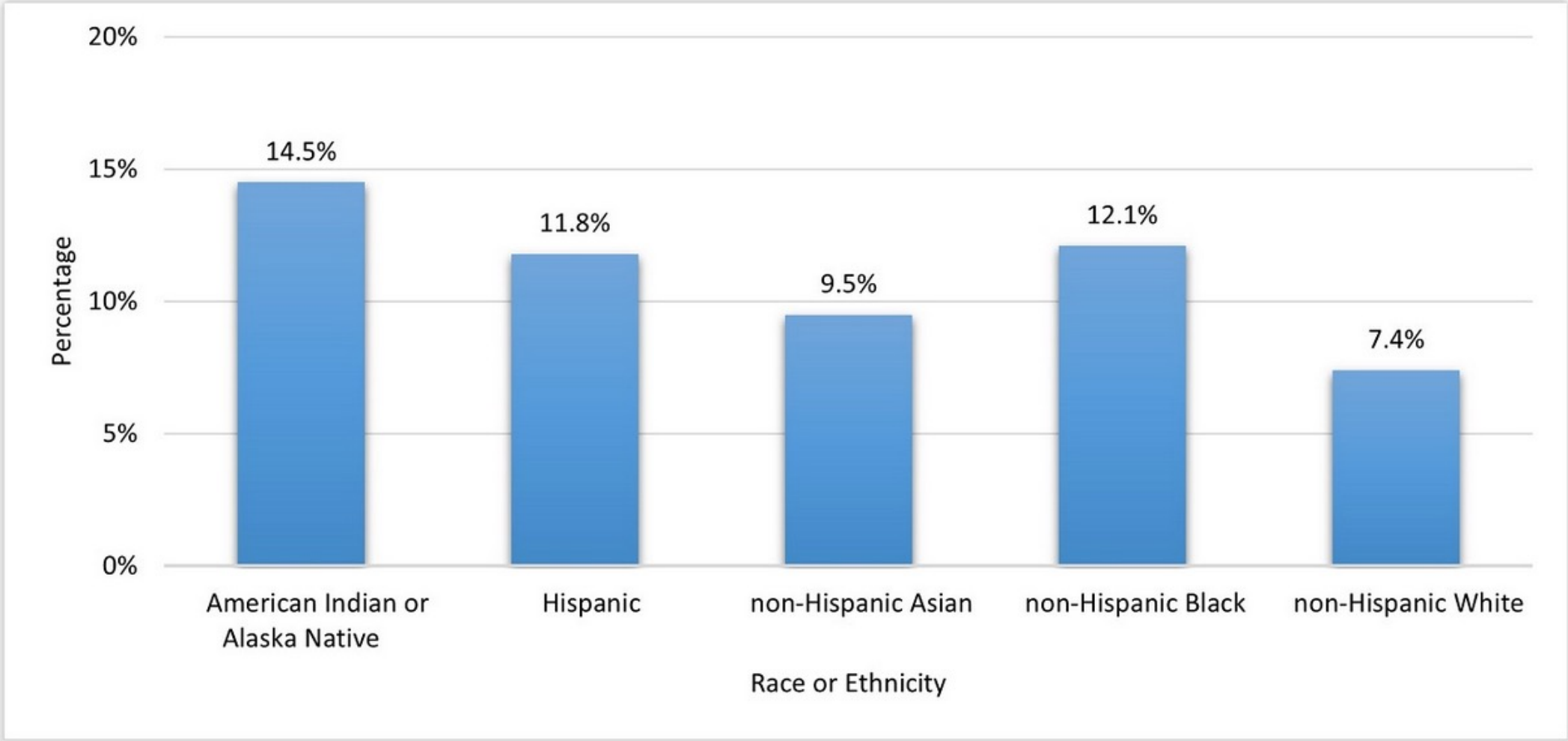
Source: CHIS, 2017 Adult Survey.2 See Appendix Table 4 for the estimated prevalence of type 2 diabetes by county in 2017.

Figure 4. Estimated age-adjusted prevalence of prediabetes in California by county, 2017



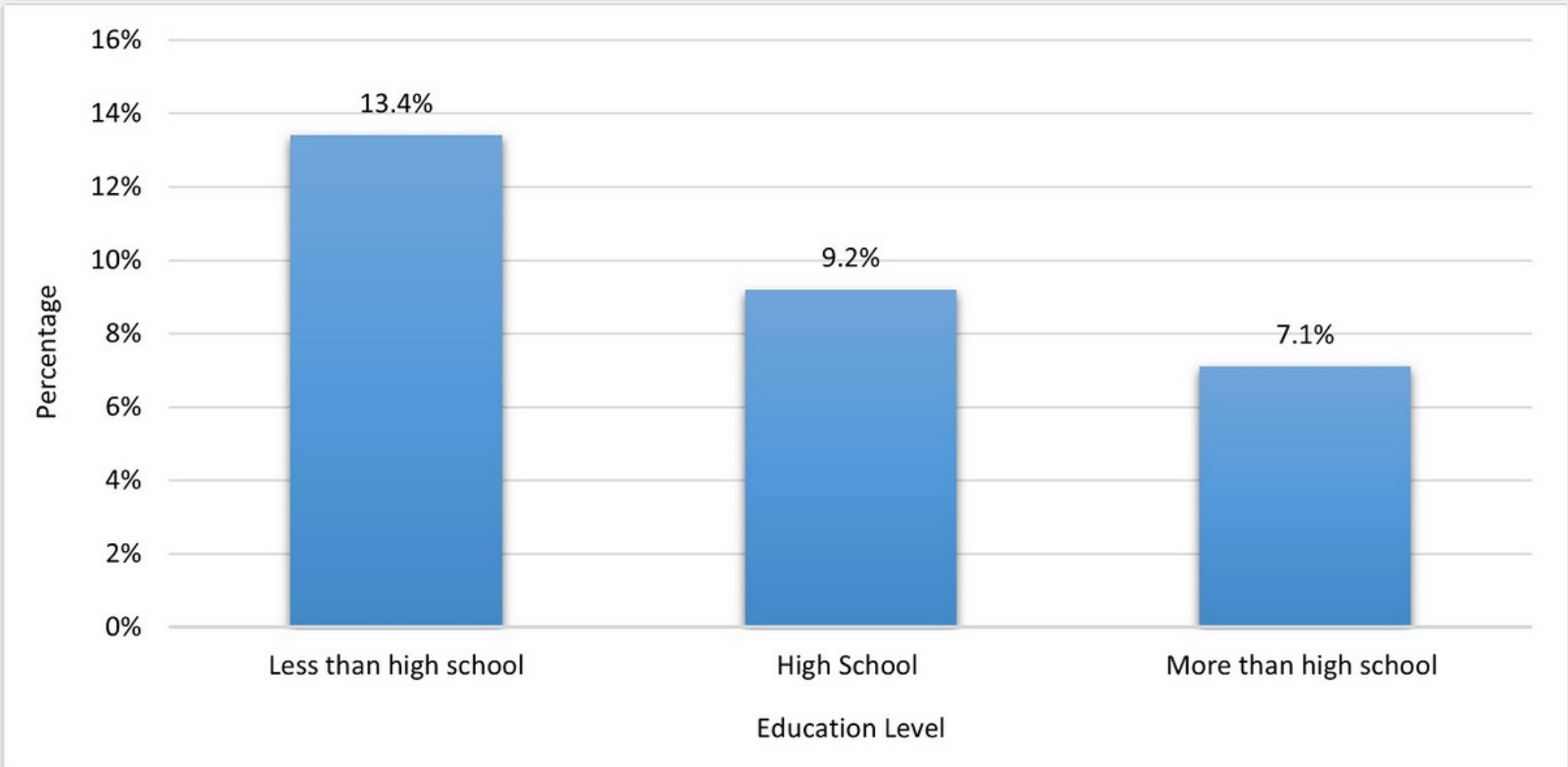
Source: CHIS, 2017 Adult Survey.

Figure 4. Percentage of Adults Aged 18 Years or Older With Diagnosed Diabetes, by Racial or Ethnic Group, United States, 2018–2019



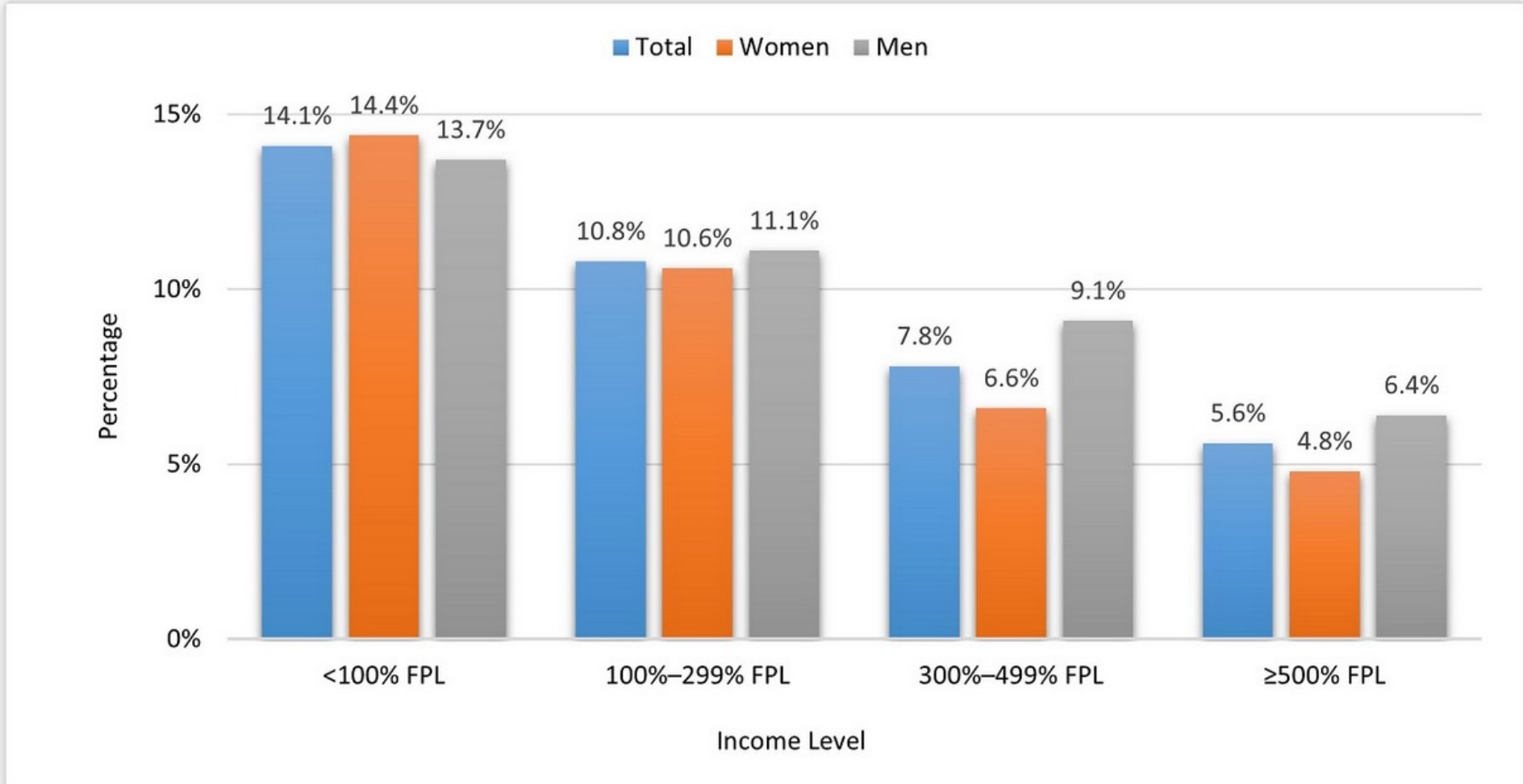
Notes: Percentages are age-adjusted to the 2000 US Census standard population. Figure adapted from CDC's *National Diabetes Statistics Report*.

Figure 5. Percentage of Adults Aged 18 Years or Older With Diagnosed Diabetes, by Education Level, United States, 2018–2019



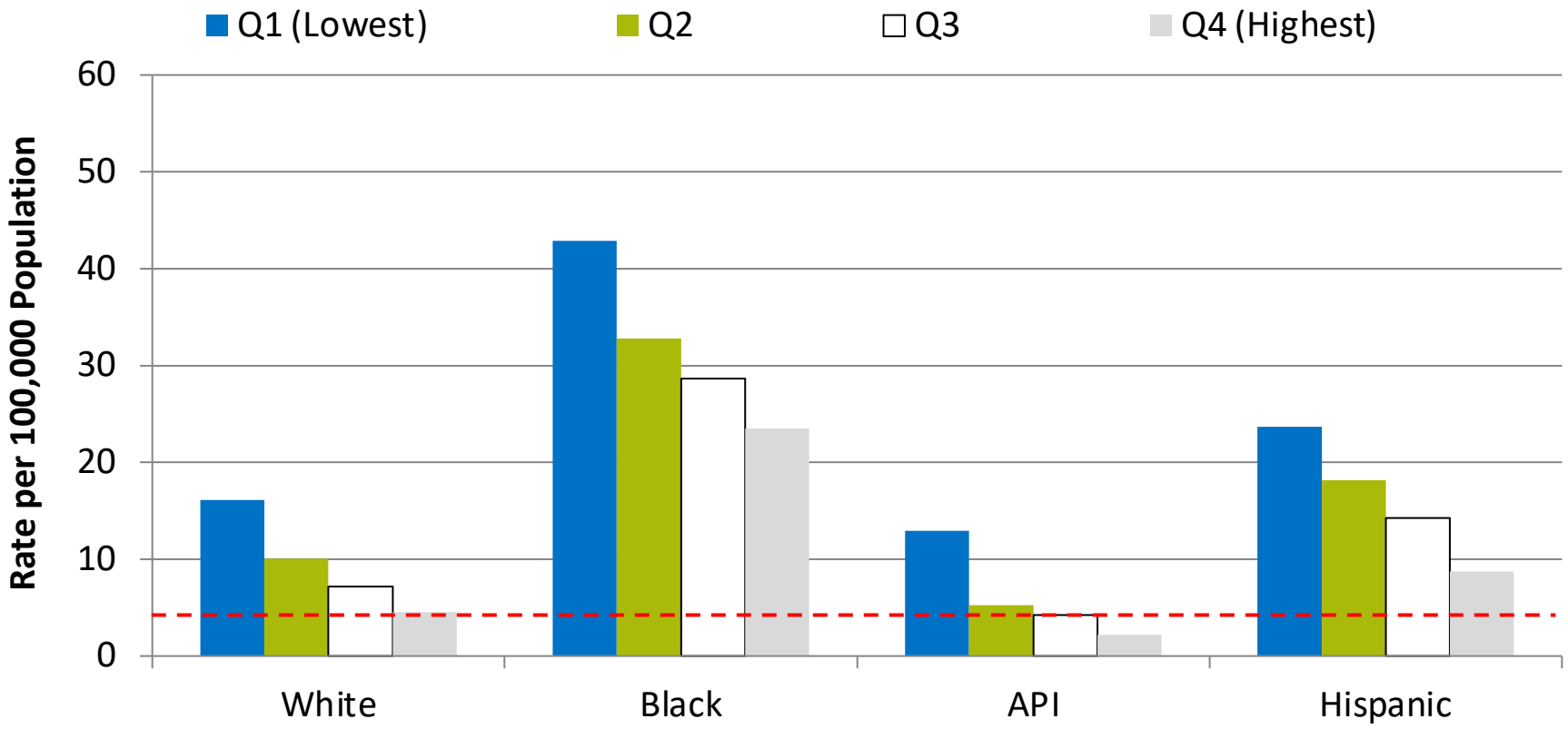
Notes: Percentages are age-adjusted to the 2000 US Census standard population. Figure adapted from CDC's *National Diabetes Statistics Report*.

Figure 6. Prevalence of Diagnosed Diabetes Among US Adults 18 or Older, by Family Income and Sex, 2018–2019



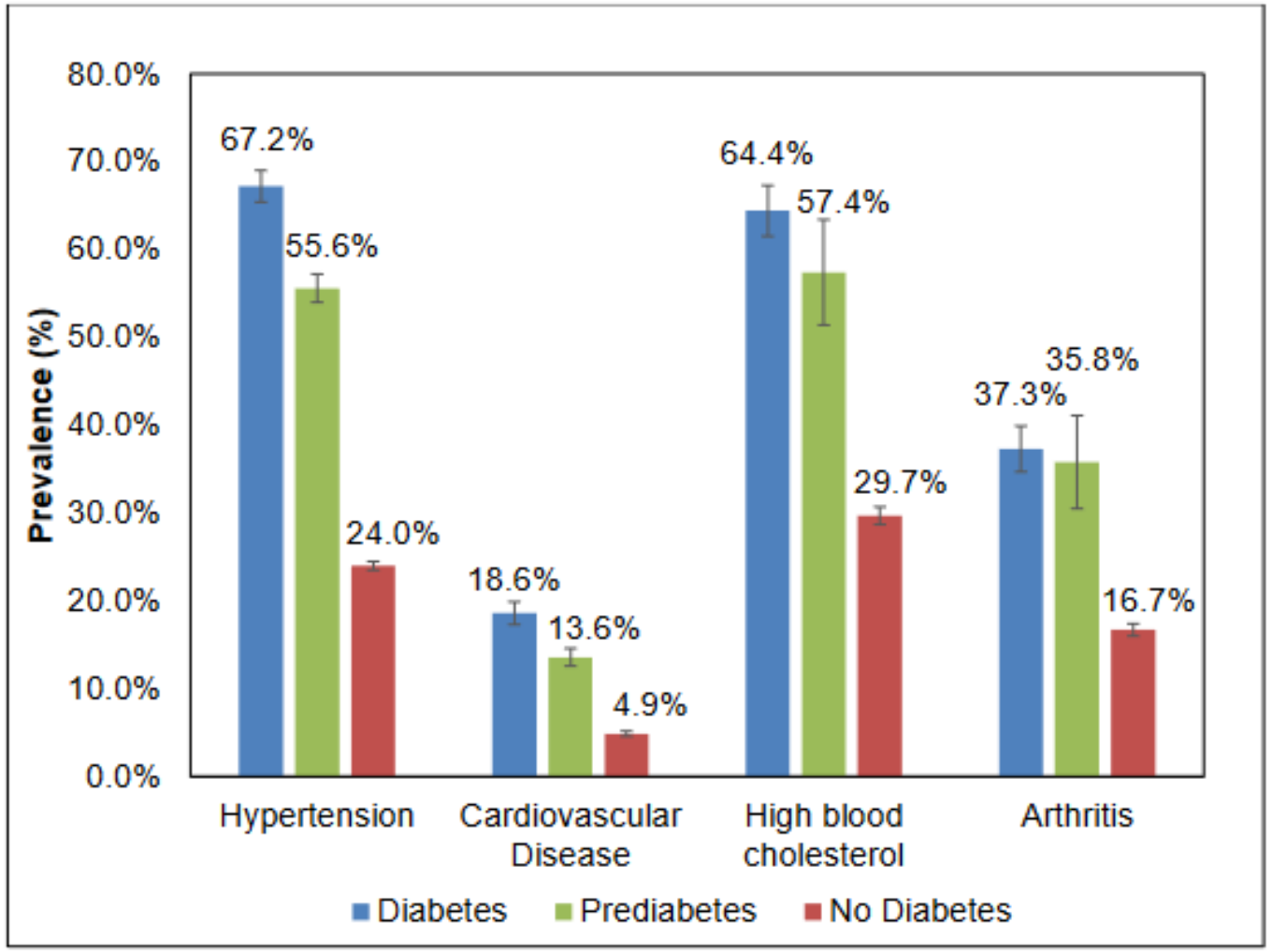
Notes: Income level based on the ratio of family income to the federal poverty level (FPL). Percentages are age-adjusted to the 2000 US Census standard population. Figure adapted from CDC's *National Diabetes Statistics Report*.

Hospital admissions for uncontrolled diabetes without complications per 100,000 population, age 18 and over, by race/ethnicity, stratified by income, 2015



Key: API = Asian or Pacific Islander; Q = quartile of median household income of the patient's ZIP code of residence
Source: Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample and AHRQ Quality Indicators, version 4.4, 2015.
Denominator: U.S. resident population age 18 and over.
Note: For this measure, lower rates are better. Area income is based on the median income of a patient's ZIP Code of residence.

Figure 9. Estimated prevalence of hypertension, cardiovascular disease, high cholesterol, and arthritis among California adults with diabetes, prediabetes, and without diabetes, 2013-2017



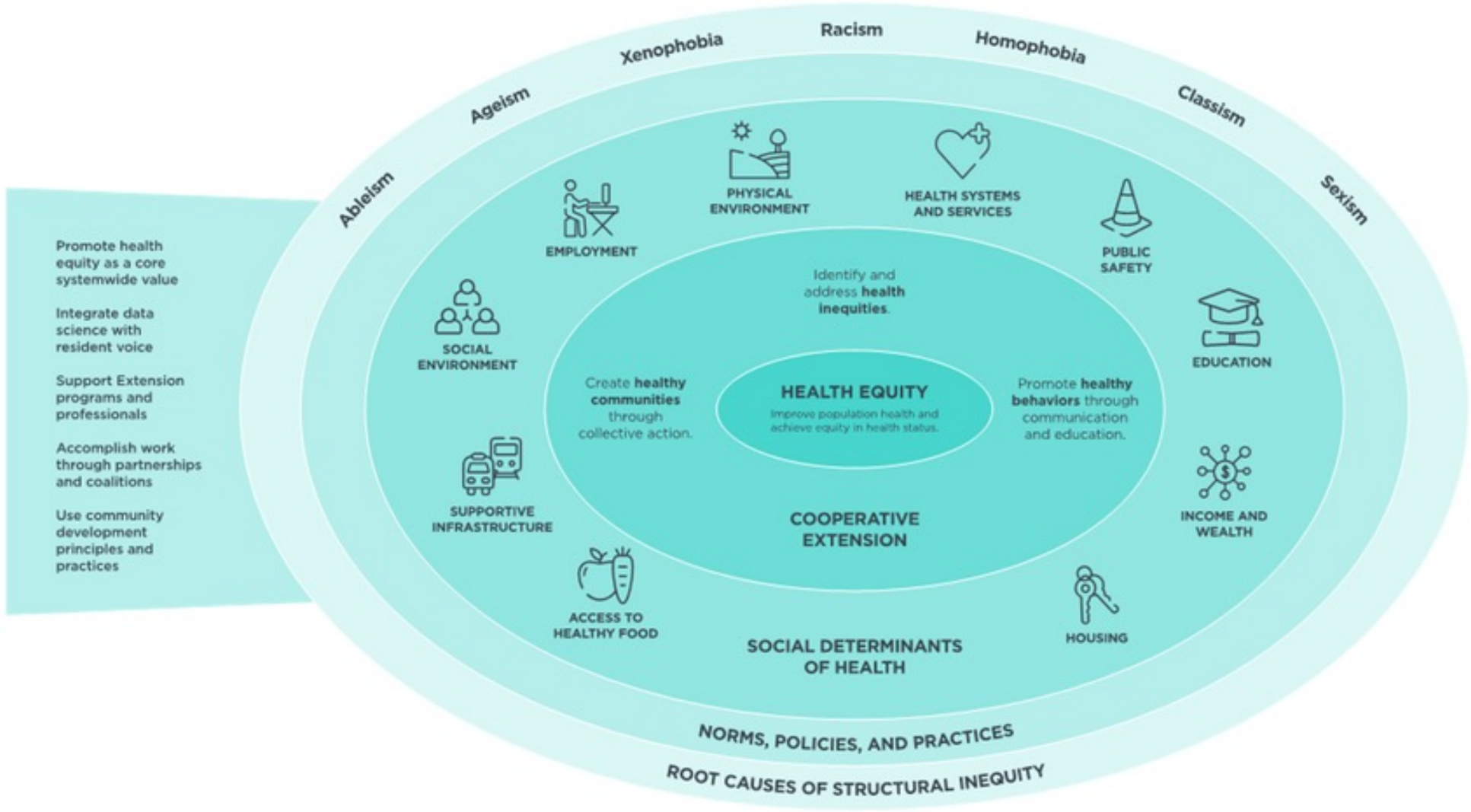
Source: CHIS, 2013-2017 Adult Survey[13] (hypertension and cardiovascular disease data) and CA BRFSS, 2015 Adult Survey[14] (high blood cholesterol and arthritis data).

Chronic diseases tend to group

Case: My patient with diabetes

- MR is a 59 y old woman with very poorly controlled diabetes who has developed signs of eye disease and kidney disease. She is obese and has arthritis of the knees. She is an immigrant from Mexico. Went to 4th grade there. Limited ability to read and write in Spanish. Has very limited English skills. Has lived in SF for 20 years, mainly working in elder care and child care. Has family in SF and in Mexico, 2 of whom are on dialysis because of diabetes. Takes two buses to come to appointments, misses many appointments because of work, can only afford the copay for medications sometimes, has had severe food insecurity at times. Has had difficulty modifying diet and exercise. Is currently doing better thanks to new medications and forms of monitoring blood sugars.

Application to Health Equity Framework



Jamboard Exercise

- Identify drivers of diabetes for MR
- Identify drivers of poor diabetes control for MR
- How do these drivers impact MR’s health outcomes?

Summary: What we did today…

- Key definitions
- Applied to case of uncontrolled diabetes
- Started thinking about how these concepts apply to own work
- Webinar 2: https://ucanr.zoom.us/j/96840522425

Contact and Evaluation Link

- Contact: Anda.Kuo@ucsf.edu
- Evaluation: https://berkeley.qualtrics.com/jfe/form/SV_5mqI27A4vixWoFU