Shifting the Lens
COVID-19 Policy Lessons for Reducing Kentucky’s Health Inequities

Foundation for a Healthy Kentucky
Kentucky Medical Association

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Deputy Commissioner for Clinical Affairs
November 19, 2020
Kentucky COVID-19 New Cases by Week (n = 144,753)

Date Cases Announced

Number of Cases

Last Updated November 18, 2020

*Reporting incomplete for current week
Distribution of Race/Ethnicity by KY Population, COVID-19 Cases, and COVID-19 Deaths

- **White**
  - KY Population: 87.6%
  - KY COVID-19 Cases: 78.9%
  - KY COVID-19 Deaths: 82.1%

- **Black or African American**
  - KY Population: 8.4%
  - KY COVID-19 Cases: 12.7%
  - KY COVID-19 Deaths: 14.0%

- **Multiple or Other Race(s)**
  - KY Population: 5.2%
  - KY COVID-19 Cases: 5.7%
  - KY COVID-19 Deaths: 2.5%

- **Asian**
  - KY Population: 1.6%
  - KY COVID-19 Cases: 2.1%
  - KY COVID-19 Deaths: 1.4%

- **Hispanic or Latino (Any Race)**
  - KY Population: 3.8%
  - KY COVID-19 Cases: 12.7%
  - KY COVID-19 Deaths: 3.7%

Excluding COVID-19 cases & deaths with missing/unknown race (n=14,281 & 66) and ethnicity (n=15,015 & 99)

Updated August 21, 2020
Distribution of Race/Ethnicity by KY Population, COVID-19 Cases, and COVID-19 Deaths

- **White**
  - KY Population: 87.6%
  - KY COVID-19 Cases: 82.7%
  - KY COVID-19 Deaths: 84.8%

- **Black or African American**
  - KY Population: 8.4%
  - KY COVID-19 Cases: 10.4%
  - KY COVID-19 Deaths: 11.4%

- **Multiple or Other Race(s)**
  - KY Population: 5.2%
  - KY COVID-19 Cases: 5.6%
  - KY COVID-19 Deaths: 2.8%

- **Asian**
  - KY Population: 1.6%
  - KY COVID-19 Cases: 1.4%
  - KY COVID-19 Deaths: 0.9%

- **Hispanic or Latino (Any Race)**
  - KY Population: 3.8%
  - KY COVID-19 Cases: 8.2%
  - KY COVID-19 Deaths: 2.9%

Excluding COVID-19 cases & deaths with missing/unknown race (n=32,755 & 122) and ethnicity (n=37,702 & 182)

Updated November 18, 2020
Hispanic Patients Tested Positive for COVID-19 in Kentucky

Unduplicated Patients

- 0
- 1 - 10
- 11 - 50
- 51 - 725

Kentucky Count: 3,194 Cases

Data file date: August 14, 2020
Date of Report: August 20, 2020
Includes confirmed and probable cases

Data Source: Kentucky Department for Public Health (KDPH)
COVID-19 Health Care Disparities Work Group
### COVID-19 Outcomes through August 10, 2020

<table>
<thead>
<tr>
<th></th>
<th>Race African American</th>
<th>Ethnicity Spanish Speaking</th>
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<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent*</td>
</tr>
<tr>
<td>Population of Kentucky</td>
<td>3,158</td>
<td>12.5</td>
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<tr>
<td>Cases</td>
<td>563</td>
<td>15.4</td>
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<tr>
<td>Hospitalizations</td>
<td>74</td>
<td>29</td>
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<tr>
<td>Incarcerated</td>
<td>107</td>
<td>14</td>
</tr>
</tbody>
</table>

* Race Percent – excludes ‘unknown race’

** Ethnicity Percent – excludes ‘unknown ethnicity’
COVID-19 Diversity Data Workgroup Summary: Race

- African Americans are 1.7 times more likely to test positive with COVID-19 compared to whites.
- African Americans that tested positive for COVID-19 are 2.6 times more likely to be hospitalized for treatment compared to whites.
- African Americans inmates in correctional facilities are 1.4 times more likely to test positive with COVID-19 compared to white inmates.
- African Americans tested positive for COVID-19 are 2.7 times more likely to die due to the disease compared to whites.
COVID-19 Diversity Data Workgroup Summary: Ethnicity

• Hispanics are 4.4 times more likely to test positive with COVID-19 compared to non-Hispanics.

• Hispanics tested positive for COVID-19 are 4.0 times more likely to be hospitalized.

• Hispanic inmates in correctional facilities are 4.1 times more likely to test positive with COVID-19 compared to non-Hispanic inmates.

• Hispanics tested positive for COVID-19 are 2.6 times more likely to die due to the disease compared to non-Hispanics.
Do the best you can until you know better. Then when you know better, do better.

Maya Angelou
Policy Considerations of Lessons Learned About COVID-19 in KY

• Karen Krigger MD, Med, FAAFP, AAHIVM(S)
• Professor Family and Geriatric Medicine, University of Louisville, School of Medicine
• Director of Health Equity Health Sciences Center, University of Louisville
• Endowed Chair of Health Policy, University of Louisville
Society of Critical Care Medicine

September 12, 2020

- ‘Addressing Disparities in COVID-19 Care’
- Sue S. Bornstein  MD FACP
- American College of Physicians
Which communities are at greatest risk?

- Black and Latinx persons in the US have been 3 times more likely to contract COVID-19 than White residents and nearly twice as likely to die from it.
- Some counties with a majority of Black residents have almost 6 times the death rate compared to predominantly White counties.
- In New Mexico, native Americans comprise only 11% of the population yet account for more than ½ of COVID-19 cases.

Why communities of lower social economic status are of higher risk?

- Higher concentration of people in homes and living spaces
- Lower percentages of individuals working from home
- Lower wage jobs with less benefits for medical services/access to care
- Lack of basic utilities, i.e., stable housing; safe, running water; electricity; inadequate healthy food resources
- More chronic disease
- Lack of access to or reliable access to internet/phone service
A new beginning

CDC Expands U.S. Diabetes Surveillance System with new Social Determinants of Health Module

New tool identifies Diabetes-Related Health Disparities

Press Release

For Immediate Release:
Tuesday, November 17, 2020

“The impact of poverty, education, geography, access to care and healthy food, transportation, and many other factors continue to have a profound effect on diabetes and other chronic conditions in the U.S.”
The Centers for Disease and Control and Prevention (CDC) has expanded the U.S. Diabetes Surveillance System with **15 new social determinants of health** (SDOH) module to help identify **under-resourced areas of the United States**, and assess the potential impact of health disparities on diabetes burden and risk factors.
What does this mean for us in Kentucky?

We need to leverage patient-centered responses to chronic disease management, and access to medical care in communities based on their community social determinants.
What are Kentucky positives?

• Expanded Medicaid Services
• One of 40 states to provide Managed Medicaid Services.
What does this mean for us in Kentucky?

- Kentucky is ranked as one of the least healthy states in the nation, according to the 2019 report from the United Health Foundation.
- The study ranked the state No. 43 out of 50 states, using five categories: behaviors, community and environment, public and health policies, clinical care, and health outcomes.

Status of State Medicaid Expansion Decisions

NOTES: Current status for each state is based on KFF tracking and analysis of state activity. Expansion is adopted but not yet implemented in MO and OK. (See link below for additional state-specific notes).

But the good news of Medicaid Expansion States!

• #43 – Kentucky ( #45 in 2018 )
• #44 Tennessee – No Medicaid Expansion
• #45 W. Va. – Yes ( was in the bottom 5 states in 2018 )
• #46 Oklahoma – Adopted but not implemented
• #47 Alabama – No
• #48 Arkansas – Yes
• #49 Louisiana – Yes (# 50 2018 )
• #50 Mississippi – No
Kynect is Back!


A one-stop, online shop for people to apply for Medicaid and a host of other resources such as food and child-care assistance, job training and help for the elderly and people with disabilities.
What can Kentucky do better?

View medical care from the patient’s perspective.
Health Care Delivery – It is all about getting the patient needed care!

• Focused health care delivery (aka 15 min appointments) and reimbursements only work for the healthy patients. The populations most impacted by chronic disease and pandemics have multiple medical problems.

• Scheduling an appointment for each medical problem means time off from work, loss of income, costs of childcare, and transportation costs for both the patient and the care providers of children and seniors.

• FMLA does not cover wages!
Health Care Delivery – It is all about getting the patient needed care!

Result:
• Patients will have less medical follow up for chronic conditions creating increased occurrences of emergency room and hospital utilization

Solution:
• Insure safe, responsive transportation
• Schedule appointments based on time needed by grouping conditions – i.e., Diabetic planned visits to include hypertension, weight, and lipids
• Case management to call ahead and identify any potential barriers – i.e., Childcare, translation services, etc., to optimize appointment arrival (on time) and to decrease “no show” rates
• Verify the intent of the visit
Health Care Delivery – It is all about getting the patient needed care!

- Create and support “carve outs” for patients at high risk for medical care utilizations with active case management services, hearing aids, eyeglasses, transportation, dentures, supportive home services, including medical home care.
  - For seniors – it is less costly to support them in their homes and most prefer being at home.
  - The sickest 5% of the population consume 50% of health care spending. By utilizing technology and ancillary service providers, you can effectively decrease costs in 1/3 of those high-utilizing patients.

https://hbr.org/2020/01/managing-the-most-expensive-patients
Health Care Delivery – It is all about getting the patient needed care!

- **Flexible office hours/Access points** – Early/late or collaborative agreements with after hour facilities, providing care to decrease emergency room utilization/hospital admissions with “real-time communication” to the medical home.

- Create **ancillary low level medical surveillance sites** in the patients’ neighborhoods (i.e., church, community center) where trained personnel would hold scheduled times for blood pressure, glucose readings, weights, peak flows readings, using technology with real time communication to the medical home, providing timely surveillance of chronic disease and medical education.
What else could ancillary medical service sites do?

• Provide services for immunizations, pregnancy testing, and sexually transmitted disease surveillance.
• But they would require training in data management/reporting, quality control, and personnel training.
• They would also require blanket medical liability insurance, provided by an affiliated agency or the state with quality control measures.
• Health Insurance should not be linked to employment
  o Thousands of Americans are currently without their health insurance linked to employment, due to the economic downturn from COVID-19
  o Additionally, all insurance policies are not equal with some employment-provided-insurance equal only to catastrophic care covering one physical exam and one acute visit a year – totally inadequate for persons with chronic illness. But it probably was the cheapest option, so patients take it.
  ▪ Consequently, patients come in for their physical exams expecting to have the diabetes, hypertension, lipids, aches and pains addressed at that visit. Is this a lack of education or necessity? NECESSITY!
Co-pays for chronic illness should be eliminated as a barrier to accessing medical care.

- *Ok, I believe all co-pays should be eliminated!*

- People with limited resources *opt out* of coming in for blood pressure checks, INR/coumadin checks, etc., when co-pays are required with financial burdens shifted to hospitals when costly potentially avoidable health crisis occurs.
Health Care Delivery – *It is all about getting the patient needed care!*  

• **Quality assurance for phone contact at medical offices**—many economically-challenged patients have limited phone plans. When they call to the office they should have a rapid response accessible in their language.

• **Free stratified medical office costs, or patient incentives** for blood pressure checks, weights, etc., administered by low level staffing with insurance reimbursement for these services tied to medical outcomes.

• **Reimbursable group visits in the medical office for**
  
  o Nutritional services – by phone or video conference or in person
  o Exercise groups – arm-chair yoga, arm-chair tai chi, exercises for home, etc.
  
  ▪ Can be done with live virtual grouping during COVID or taped sessions.
Health Care Delivery – It is all about getting the patient needed care!

- Medical education by audio/video platforms for patient medical education
- Phone trees created for 5-minute tutorials on diabetes, hypertension, STDs, etc.
- Examples of the 4\textsuperscript{th} telemedicine modality
  - [https://sites.google.com/view/compassionclinic/educational-videos](https://sites.google.com/view/compassionclinic/educational-videos)
  - [https://www.youtube.com/results?search_query=+compassion+clinic+university+of+louisville](https://www.youtube.com/results?search_query=+compassion+clinic+university+of+louisville)
Is there a role for patient responsibility in health care?

Absolutely!

- They need to show up for appointments
- They need to answer the phone when service providers call – a challenge in the era of “spam” calls.
- They have to be given the opportunity to ask:
  - What can I do to be healthier?
  - To be better?
  - To not take these medications?

- In which case, we need to support them!
What supports can we give patients engaged in their healthcare, besides medical access?

For Kentucky, that means:
Mental health services access and support
Nutritional education access and support
Medical education access and support (blood pressure cuffs, scales, etc.)
Exercise education access, resources, and support
• Realign medical care around patient needs with services in their neighborhoods for basic screenings and surveillance by “trained” personnel, using real-time technology to communicate with the medical home

• “Carve Out” high-risk utilizers with enhanced services and contact with multidisciplinary teams (i.e., 5 or more chronic diseases)

• Provide enhanced medical and support services for seniors in their homes

• Utilize patient medical education and medical services via phone, videoconference, internet platforms

• Encourage “group visits” in medical offices for chronic disease management, education, and peer support.
References

- Bornstein, Sue S. MD, FACP American College of Physicians, Society of Critical Care Medicine, Sept. 12, 2020, “Addressing Disparities in COVID-19 Care.”
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References

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Thank-you very much!

Questions ??

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