



Health Care Disparities

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WHY DO HEALTH CARE DISPARITIES MATTER



Health Care Disparity – difference in health and health care between population groups.

“Health disparity,” generally refers to a higher burden of illness, injury, disability, or mortality experienced by one population group relative to another group.

- Access to care
- Quality of care
- Race and ethnicity

* Occurs across many dimensions, including socioeconomic status, age, location, gender, disability status, and sexual orientation.

WHAT ARE HEALTH CARE DISPARITIES?

- ~ Disparities in health and health care limit continued improvement in overall quality of and result in unnecessary costs.
- ~ Recent analysis estimates that 30% of direct medical costs for Blacks, Hispanics, and Asian Americans are excess costs due to health inequities
- ~ Economy loses an estimated \$309 billion per year due to the direct and indirect costs of disparities.
- ~ As the population diversifies, people of color (POC) projected to account for over half of the population by 2050, it is increasingly important to address health disparities.



STATUS OF HEALTH AND HEALTH CARE DISPARITIES TODAY?

Example: 57 y/o black male

- No Insurance
- E.R. major source of care
- Only when necessary works hard labor job
- Finally goes to E.R. after he can't ignore numbness, leaking sore on foot, frequent urination and excessive thirst
- A1c 19.5

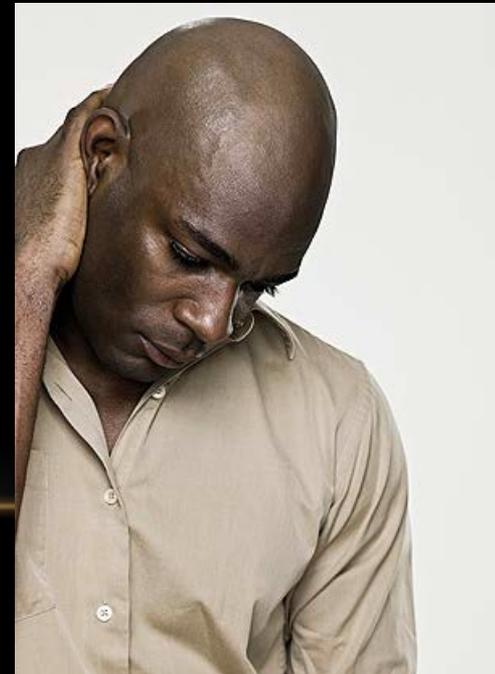


Figure 1

Excess Medical Expenditures Due to Health Inequities

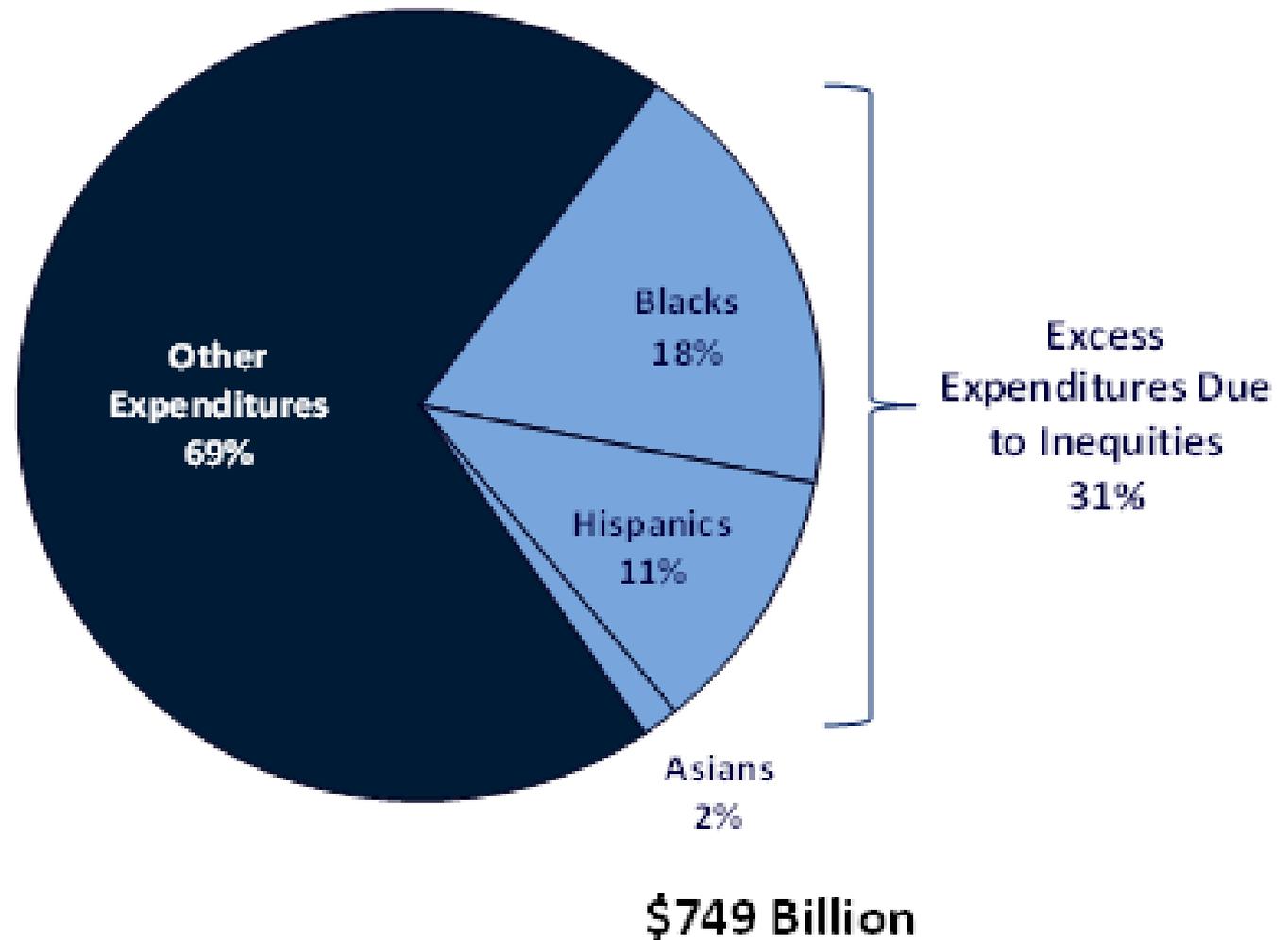
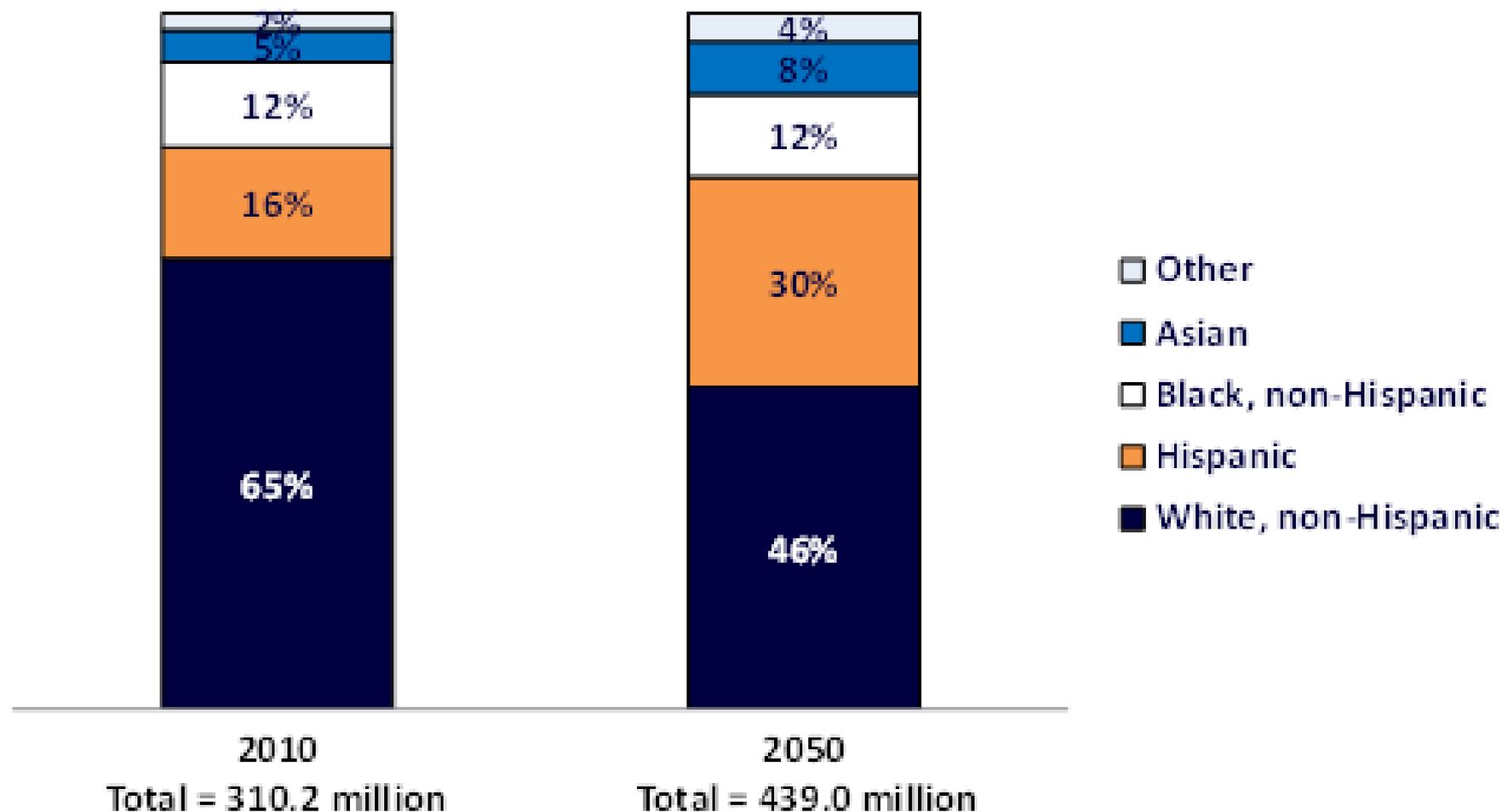


Figure 2

Distribution of U.S. Population by Race/Ethnicity, 2010 and 2050

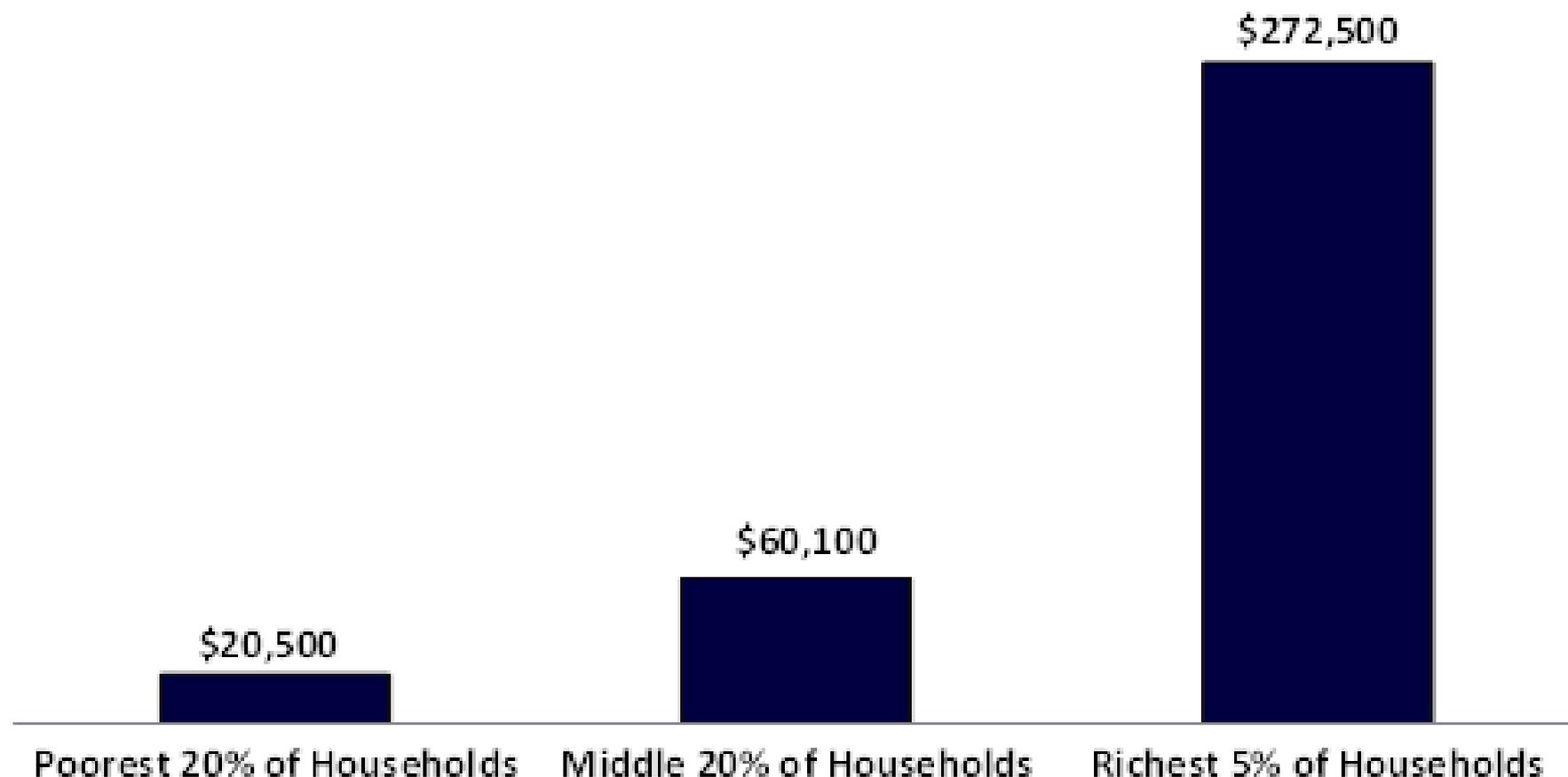


NOTES: All racial groups non-Hispanic. Other includes Native Hawaiians and Pacific Islanders, Native Americans/Alaska Natives, and individuals with two or more races. Data do not include residents of Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Mariana Islands.

SOURCE: U.S. Census Bureau, 2008, Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: July 1, 2000 to July 1, 2050. <http://www.census.gov/population/www/projections/downloadablefiles.html>.

Figure 3

Gaps Between Average Income of the Richest and Poorest Households in the United States



SOURCE: Economic Policy Institute/Centers on Budget and Policy Priorities analysis of U.S. Census Bureau Data. Income is post-federal tax and includes the value of the EITC, food stamps, and housing subsidies. Income is adjusted for inflation (to 2009 dollars) and for household size. Pulling Apart, A State-by-State Analysis of Income Trends, November 15, 2012. <http://www.cbpp.org/cms/index.cfm?6=view&id=3860>.

VULNERABLE POPULATIONS FACE INCREASED BARRIERS TO HEALTH CARE AND RECEIVE POORER QUALITY CARE

~ Agency for Healthcare Research and Quality (AHRQ) low income individuals and people of color experience more barriers and receive poorer quality care.

~ Individuals with limited English proficiency are less likely than those who are English proficient to seek care even when insured.



WHAT KEY INITIATIVES ARE IN PLACE TO ELIMINATE DISPARITIES?

- Significant recognition of health and health care disparities began about a decade ago with several landmark reports and the first major legislation focused on reduction of disparities.
 - Minority Health and Health Disparities Research and Education Act of 2000, which created the National Center for Minority Health and Health Disparities.
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WHAT KEY INITIATIVES ARE IN PLACE TO ELIMINATE DISPARITIES?

- In 2010, the Department of Health and Human Services (HHS) developed an action plan for eliminating racial and ethnic health disparities. The HHS Disparities Action Plan establishes a vision of,

“A nation free of disparities in health and health care...”

- States, local communities, private organizations, and providers also are engaged in efforts to reduce health disparities.
 - Racial and Ethnic Approaches to Community Health (REACH)
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HOW DOES THE AFFORDABLE CARE ACT IMPACT HEALTH AND HEALTH CARE DISPARITIES?

Some of the provisions explicitly focus on disparities, whereas others have broader goals with important benefits for vulnerable populations.

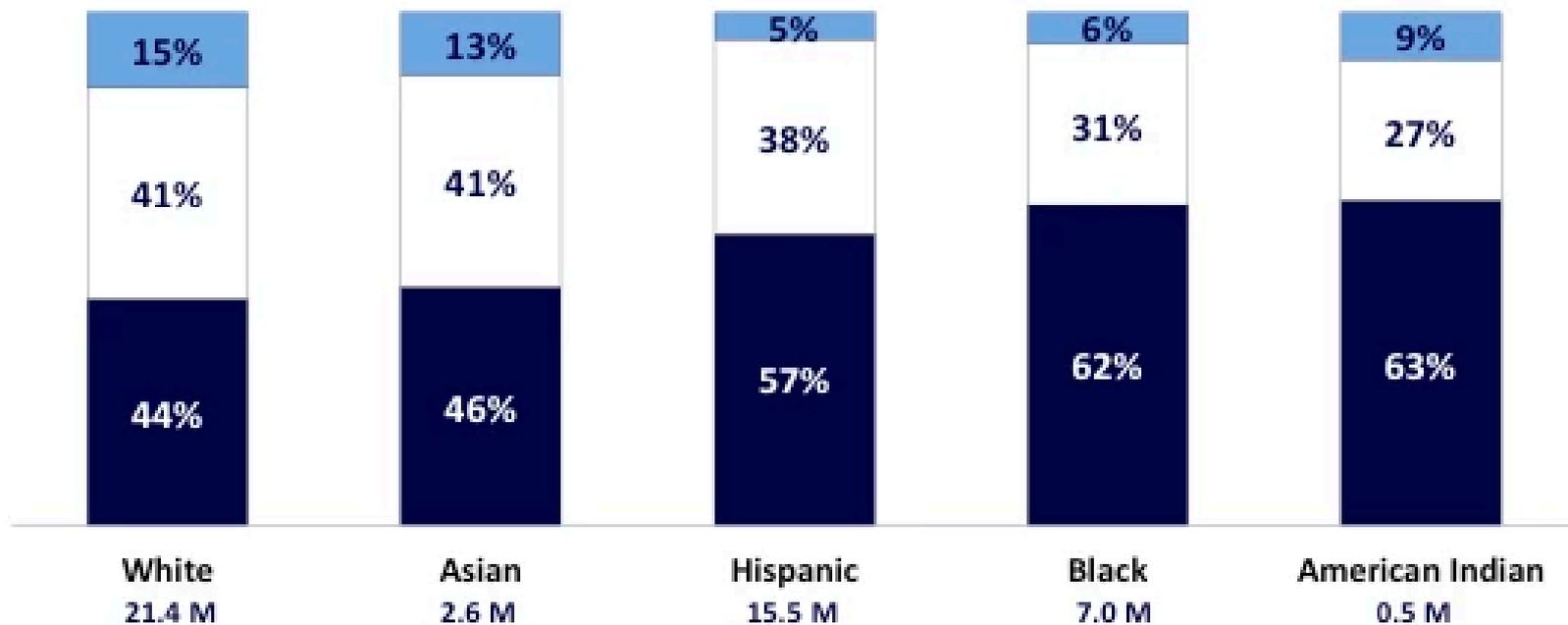
Most important factor of ACA – poverty line was decreased to allow more of the indigent population to qualify for insurance coverage (i.e. Medicaid)



Figure 14

Income of Nonelderly Uninsured by Race/Ethnicity, 2011

- 400% FPL+
- 139-399% FPL (Eligible for Subsidies)
- At or below 138% FPL (Medicaid Expansion Limit)



The federal poverty level was \$18,530 for a family of three in 2011. Asian group includes Pacific Islanders. American Indian group includes Aleutian Eskimos. Two or more races excluded. Data may not total 100% due to rounding.
SOURCE: KCMU/Urban Institute analysis of 2012 ASEC Supplement to the CPS.

HOW DOES THIS AFFECT OUR PRACTICES?

Identify your patient load

- Age
- Gender
- Socioeconomic
- Race/ethnicity



What are major disparities for each category or cross section

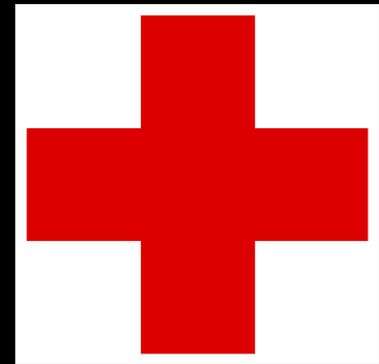
- Age i.e. young black, poor, or older white rich male/female

Socioeconomic probably most important cross section

HOW DOES THIS AFFECT OUR PRACTICES?

****Socioeconomic probably most important cross section****

- Treatment protocol must be tailored
- Costs of medicines prescribed
- High hospital readmission rate
- Compliance of certain dressings due to home environment
- Access to subsequent or previous case
- Dedication of medical personnel in areas of care



IDENTIFICATION HAS HELPED

Measles Outbreak

- 89-91
 - 55,662 cases of Measles
 - 11,000 hospitalizations
 - 123 deaths

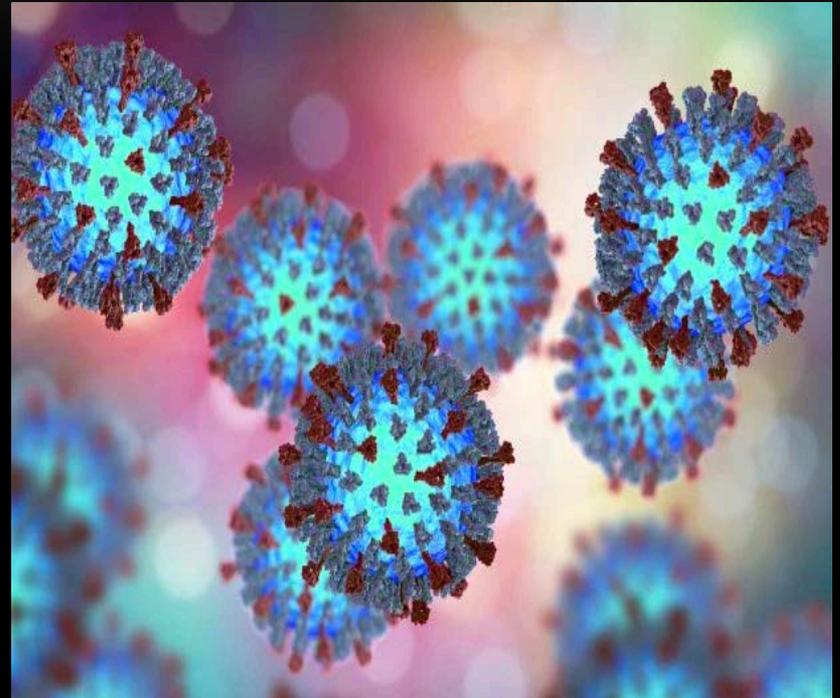
Affected:

African American

Hispanic

Low income

Development of Childhood Immunization Initiative



IDENTIFICATION HAS HELPED

Development of Childhood Immunization Initiative

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Reduce cost thru VFC
(Vaccines for Children)

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Pediatrician Initiatives Education

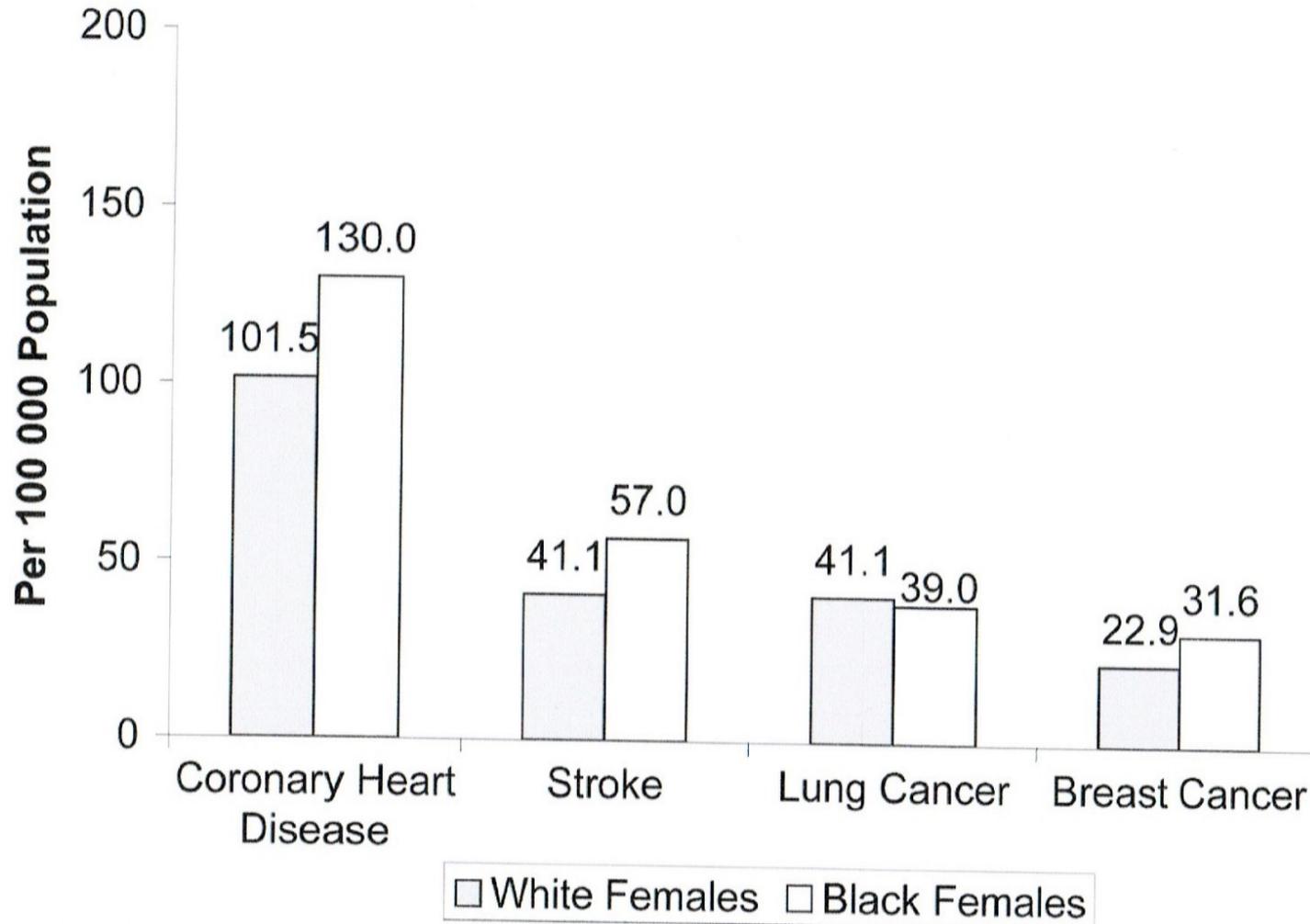
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School Requirements

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Total Reduction

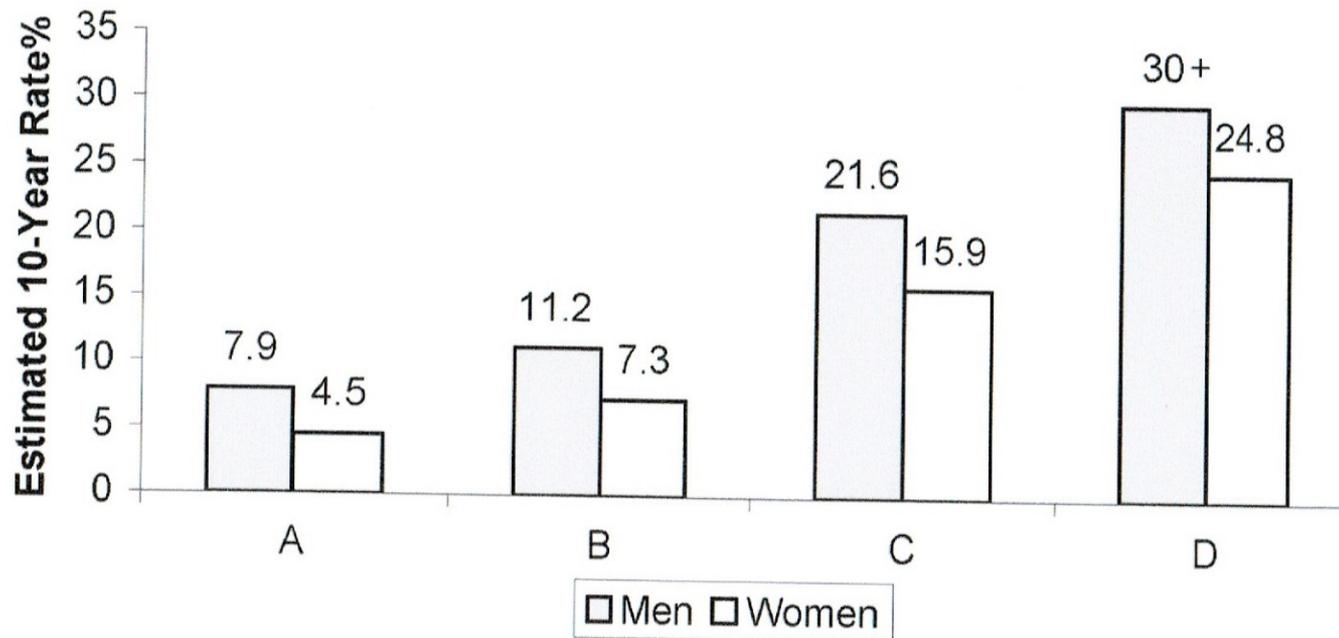
Chart 2-16.



WRITING GROUP MEMBERS et al. *Circulation*.
2010;121:e46-e215



Chart 2-20.

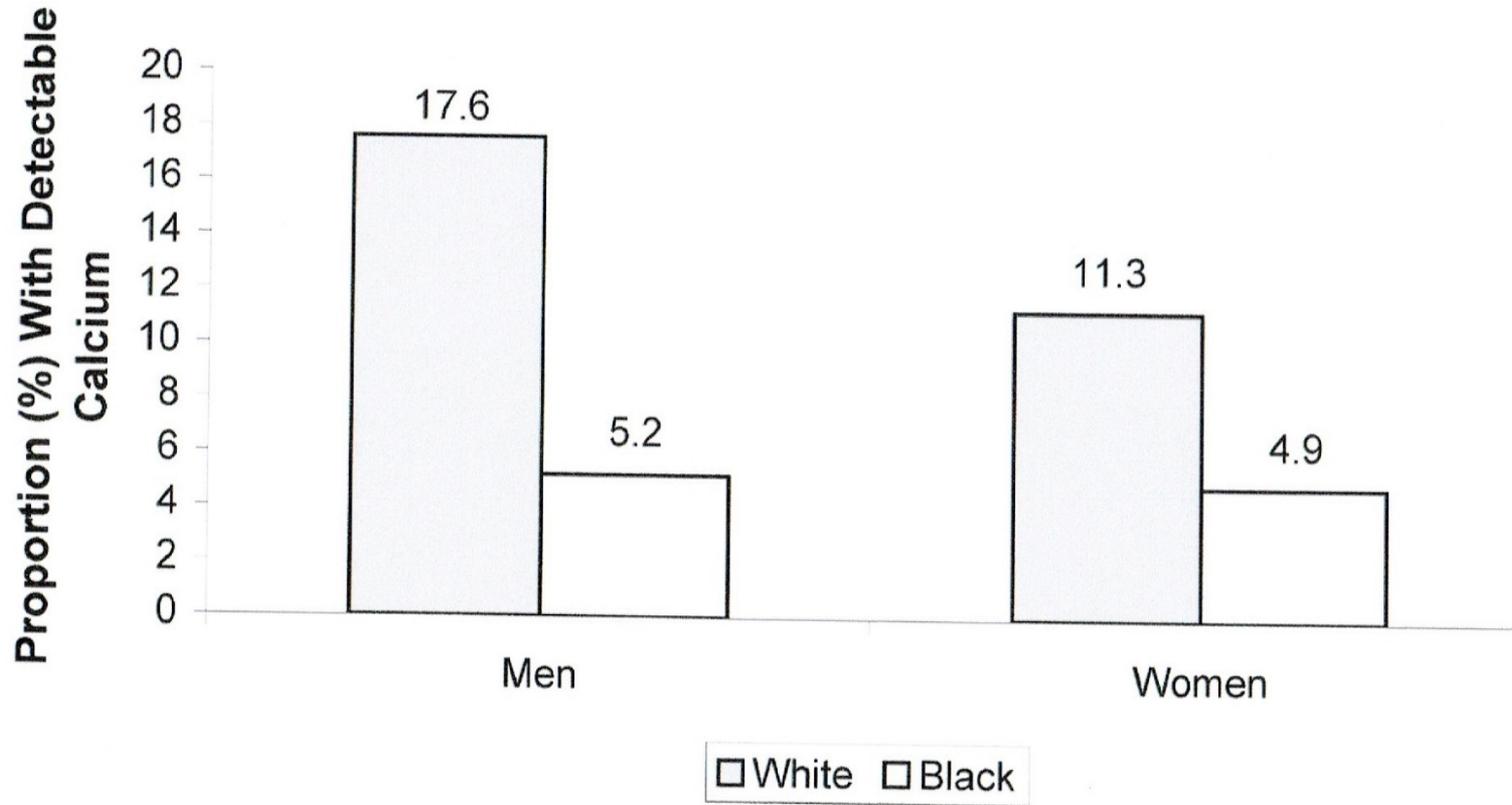


	A	B	C	D
Age	50-54	50-54	50-54	50-54
HDL Cholesterol, mg/dL	45-49	45-49	35-34	35-34
Total Cholesterol, mg/dL	160-199	200-239	200-239	200-239
Systolic BP mm/Hg, no treatment	120-29	130-139	130-139	130-139
Smoker	No	No	No	Yes
Diabetes	No	No	Yes	Yes

WRITING GROUP MEMBERS et al. Circulation.
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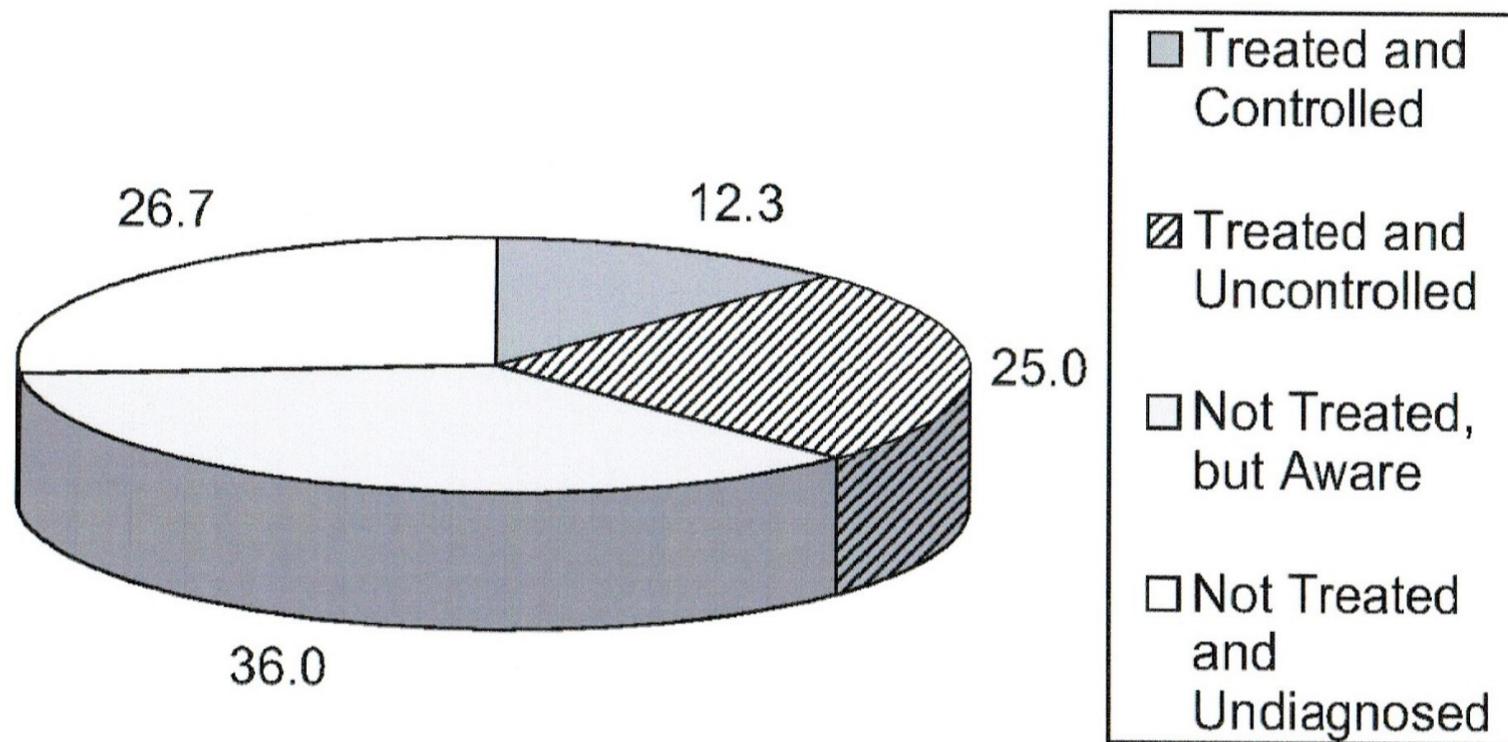
Chart 3-1.



WRITING GROUP MEMBERS et al. *Circulation*.
2010;121:e46-e215



Chart 14-4.



WRITING GROUP MEMBERS et al. *Circulation*.
2010;121:e46-e215



Chart 2-5. Blacks and Hispanics have lower levels of educational attainment.

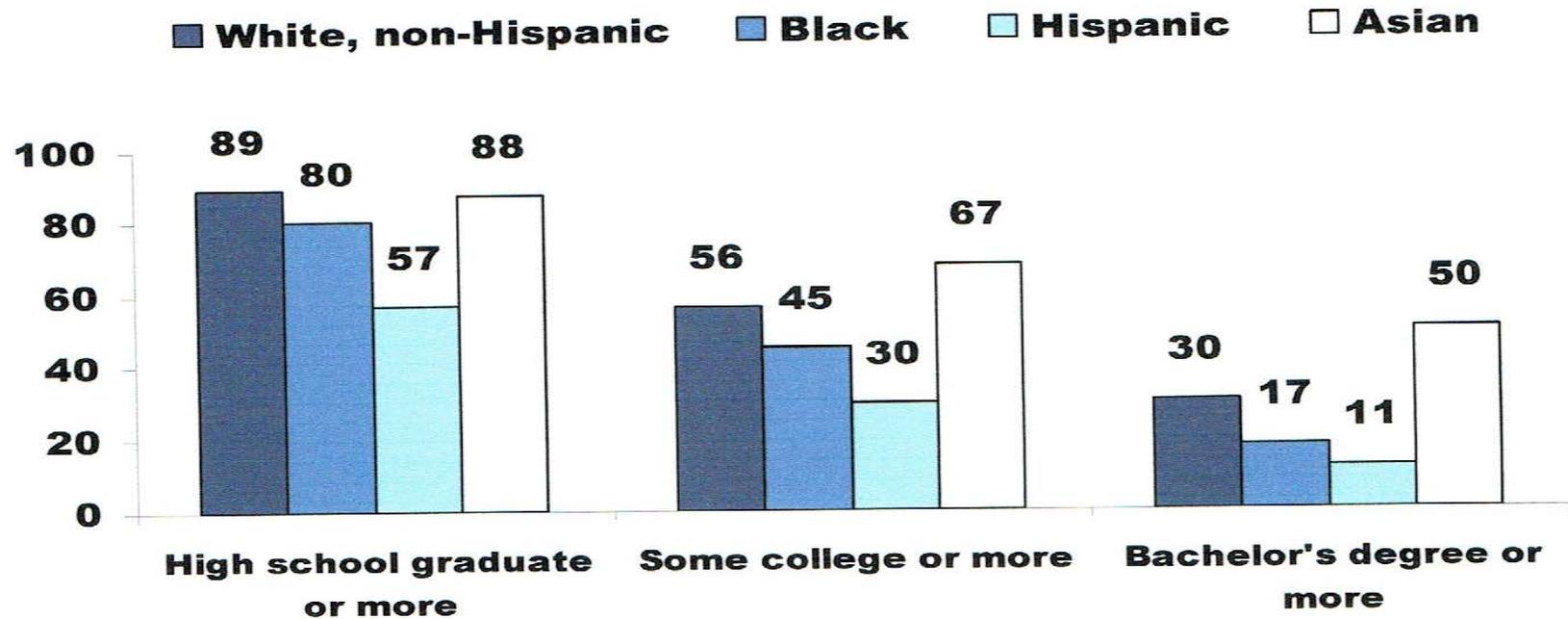


Chart 3-11. Black men and women are more likely to die from heart disease than all other racial/ethnic groups.

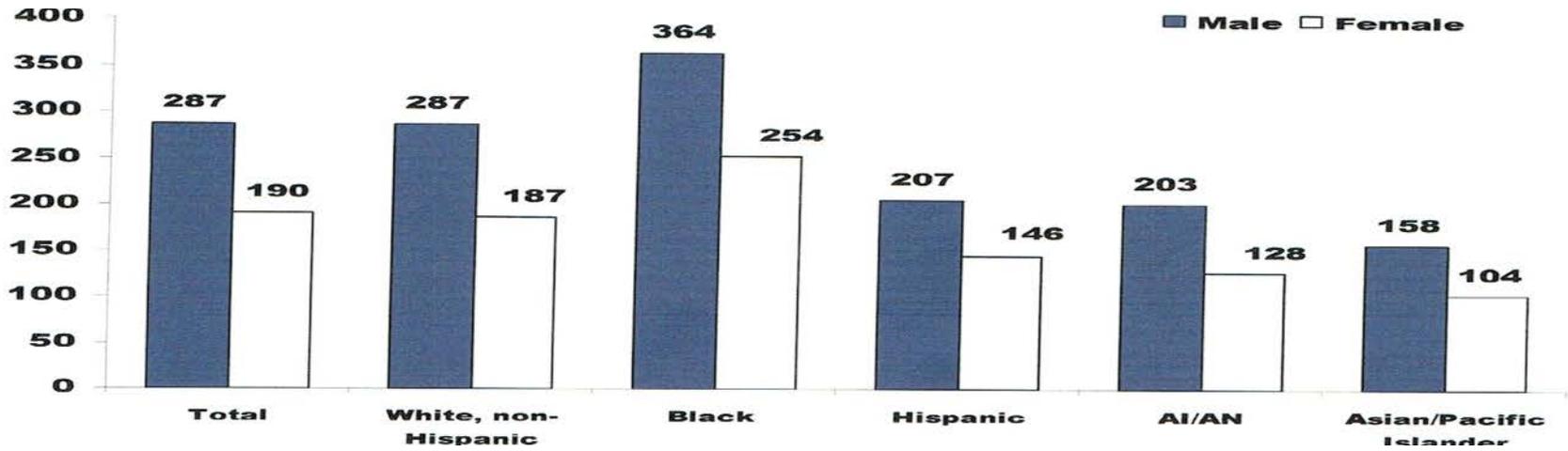


Chart 3-17. Blacks are 10 times more likely than whites and nearly three times more likely than Hispanics to have AIDS.

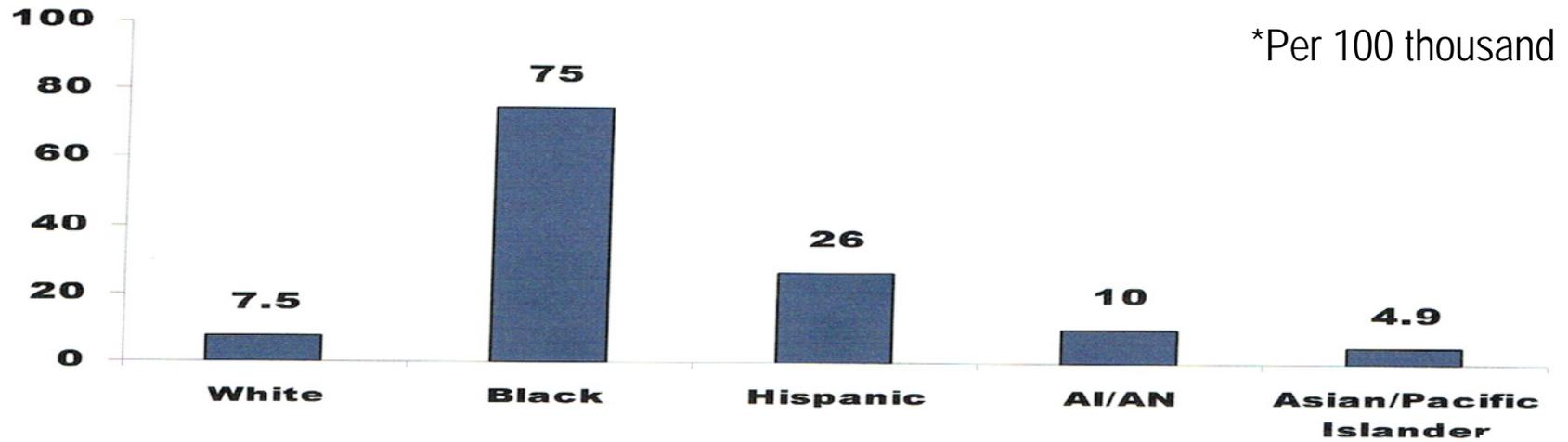


Chart 4-2. Hispanics are least likely of all racial/ethnic groups to use a private doctor and most likely to use a community health center as their usual place of care.

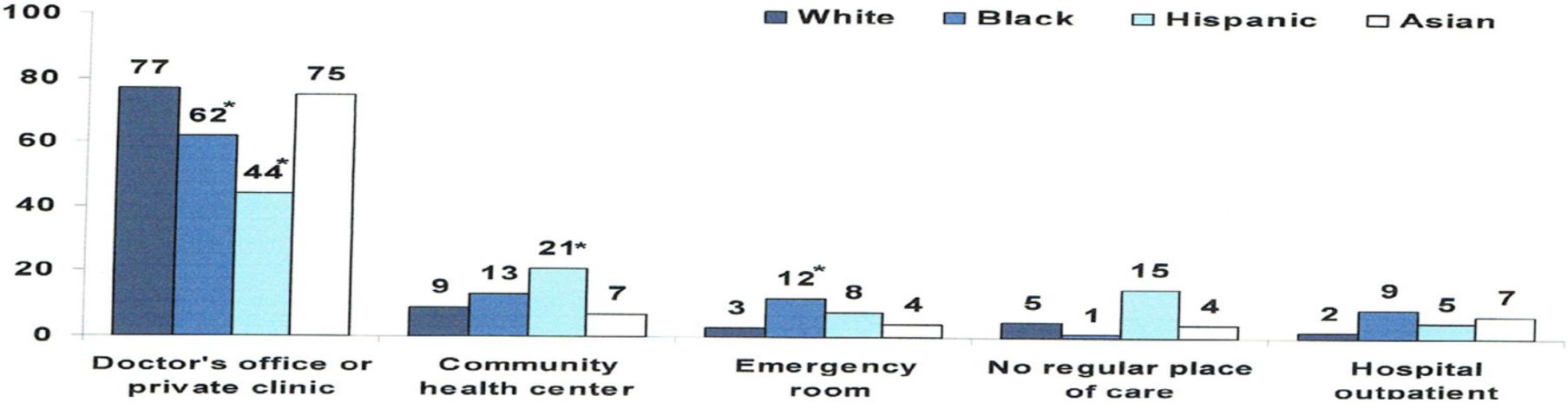


Chart 4-3. Asians and Hispanics are more likely than whites and blacks to go without needed care.

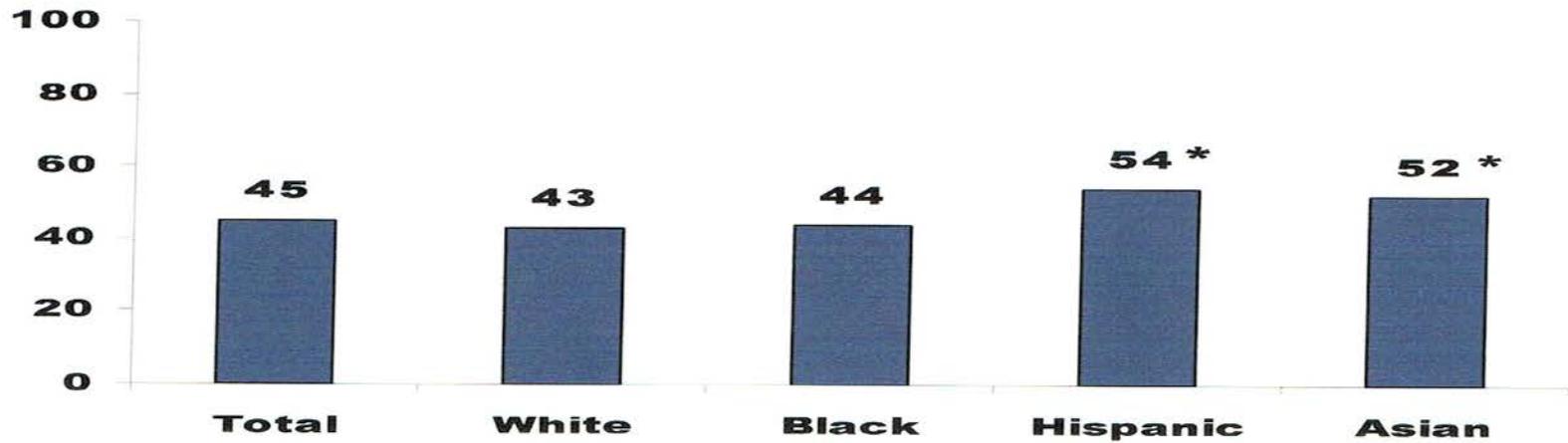


Chart 6-5. Safety: Blacks are more likely to suffer postoperative complications than other racial/ethnic groups.

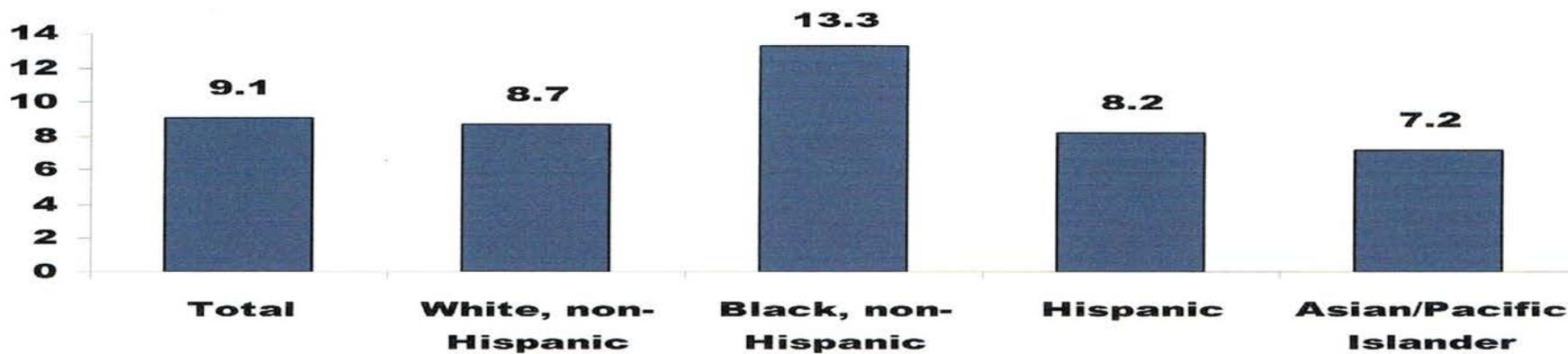


Chart 6-9. Timeliness: Blacks are more likely than whites to leave the emergency department without being seen.

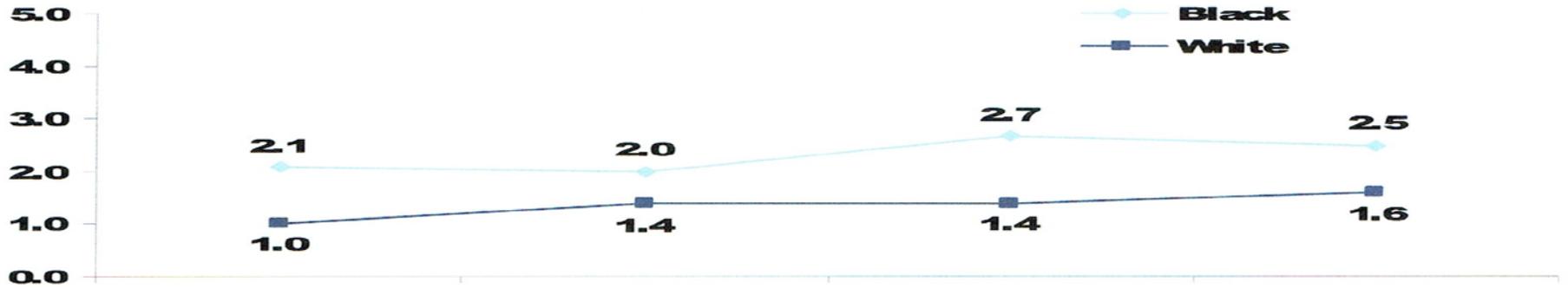


Chart 6-15. Effectiveness: Minorities are less likely to have ever received a pneumococcal vaccination than whites.

Percentage of adults age 65 and over who have ever had a pneumococcal vaccination

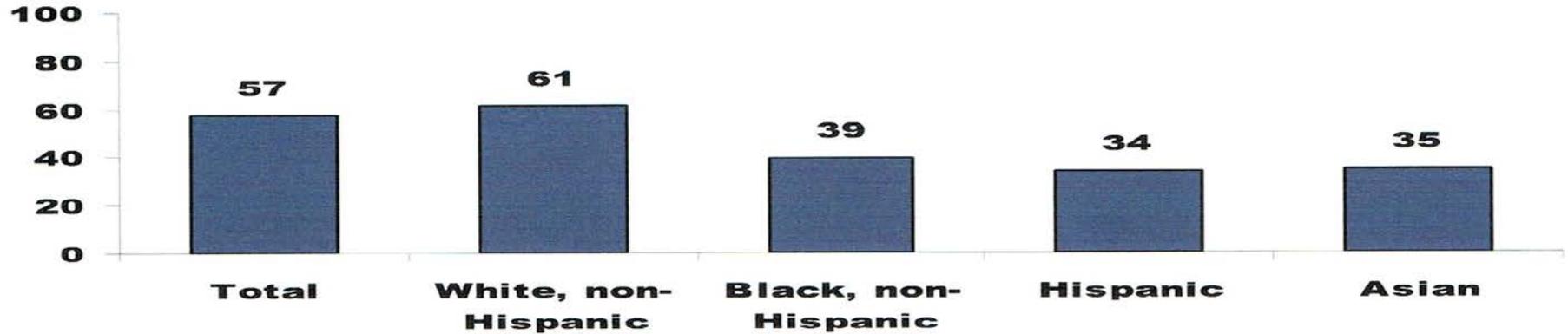
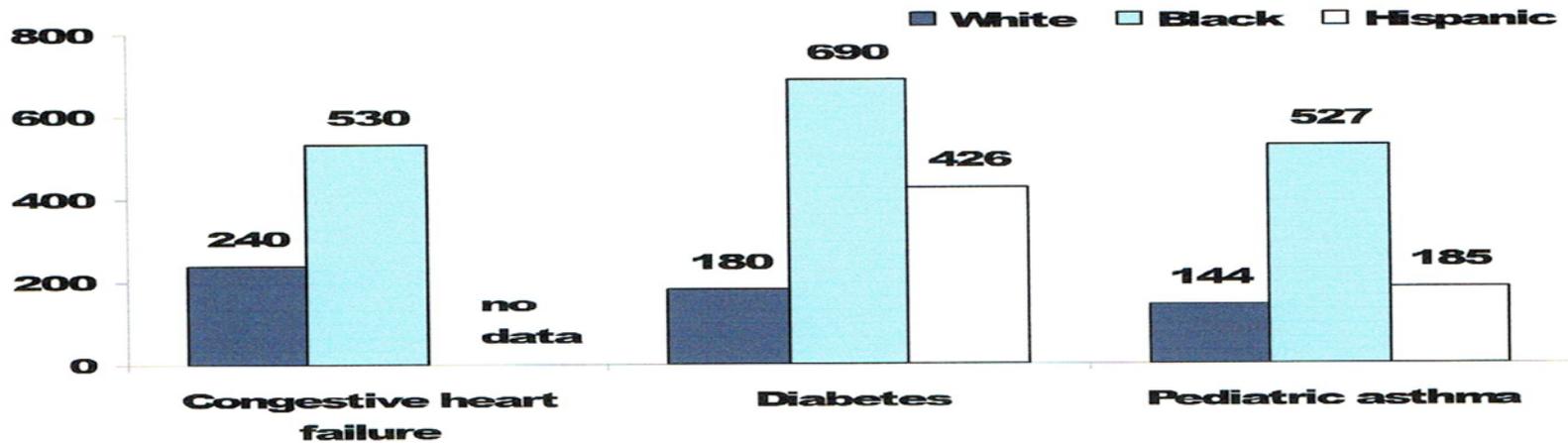


Chart 6-22. Efficiency: Blacks are two to four times more likely than whites and Hispanics to be hospitalized for potentially preventable conditions.

Rate of ambulatory care sensitive admissions per 100,000 hospital admissions



Questions You're Probably Asking

- What constitutes health-care disparity?
- What is health disparity?



Health-Care Disparity

Population-specific difference in presence of disease, access to facilities/resources, or outcomes that reflect social inequalities.



Health Disparity

- Previously only associated with race and ethnicity
- A higher burden of illness, injury, disability, or mortality experienced by one specific population group relative to another

The Challenges

- Health-care disparities have been a longstanding challenge to overcome
- Receive less quality care
- Receive lower quality care
- Experience worse health outcomes

Health Inequality

- These differences can't be explained by
 - health-care needs;
 - individual patient preferences; or
 - treatment recommendation.

Why Bother



Health-Care Disparities Affect Everyone

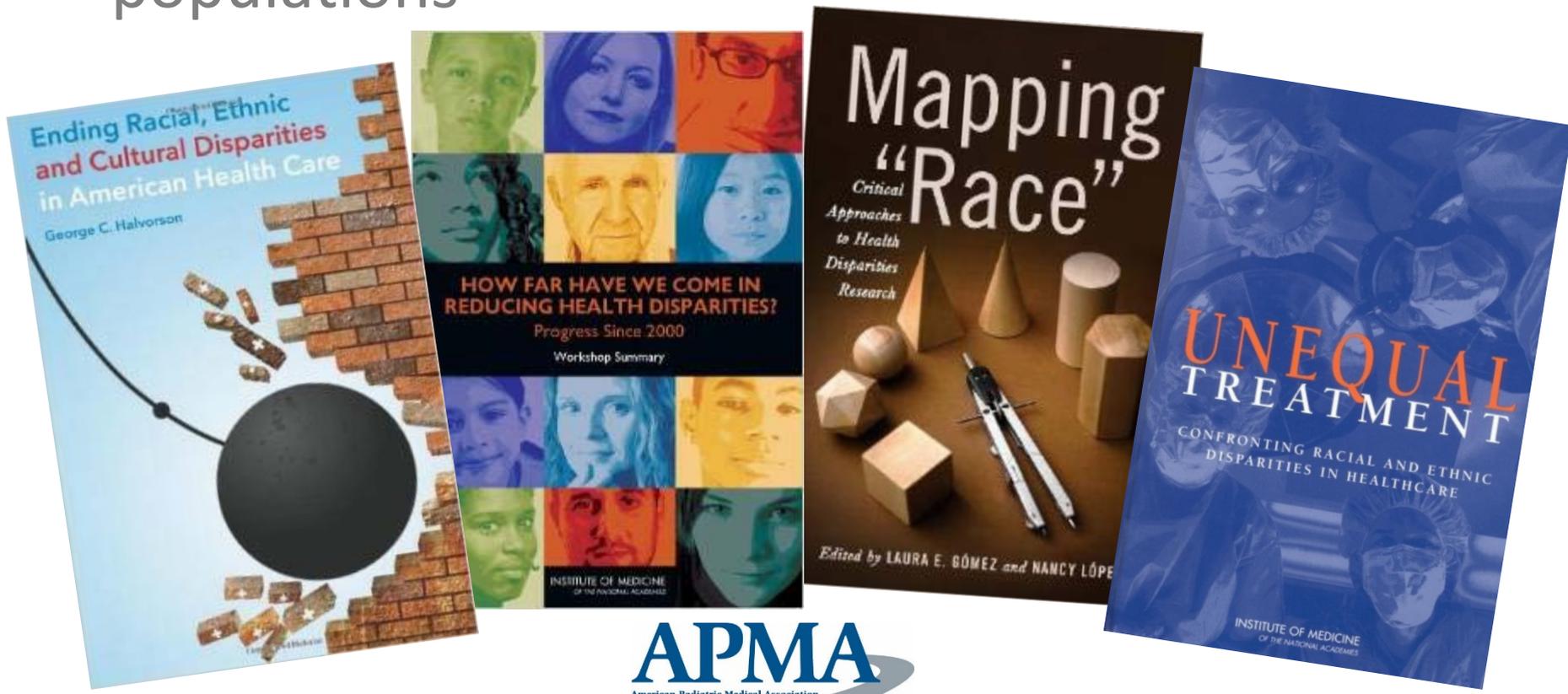
- They limit overall quality of care.
- They have a growing impact as the US population becomes more diverse.
- They affect population health, which is dependent on improving the health of the *entire* population.
- They add costs unnecessarily.

Status of Disparities in the US

- Vulnerable populations
 - People of color
 - make up more than half of population by 2050
 - account for 30 percent of direct medical costs
 - Blacks, Hispanics, and Asians considered excess costs due to health-care disparities
 - Not just people of color
 - Low-income
 - non-elderly whites without children
 - low English proficiency
 - Face increased barriers
 - Receive poorer quality of care

Poorer Health Status, Conditions, and Outcomes

- Disproportionately affect vulnerable populations



Disparities Associated with Diabetic Foot

- Vulnerable populations have a disproportionate burden
- Lower quality of care
- Exists for people of color, whites, and non-minorities
 - 50-percent increase in complications including amputation, sepsis, and death
 - Worsening of patient care with increased inpatient admissions, lengths of stay, and cost associated
 - Restricting preventive care may have resulted in unintended consequences, particularly among the poor and underserved

Lack of Insurance

- More than any other demographic or economic barrier, negatively affects quality of health care
- Uninsured are disproportionately people of color



What initiatives are out there?

- Minority Health and Health Disparities Research and Education Act of 2000
 - Created the National Center for Minority Health and Health Disparities
 - Agency for Healthcare Research and Quality (AHRQ) to regularly measure progress on reduction of disparities

US Department of Health and Human Services

- Developed an action plan for eliminating racial and ethnic health disparities
- "The HHS Disparities Action Plan"

Agency for Healthcare Research and Quality (AHRQ)

- AHRQ conducts research that focuses on:
 - identifying disparities in health-care quality and outcomes; and
 - how health care is provided to people of different racial and ethnic backgrounds.

The National Partnership for Action to End Health Disparities (NPA)

- Increase the effectiveness of programs that target the elimination of health disparities
- Address issues such as insufficient education, inadequate housing, exposure to violence, and limited opportunities to earn a livable wage

National Institute on Minority Health and Health Disparities

- Based out of the NIH
- Research current and emerging health needs of racial and ethnic minorities and other health disparity groups
- Support research-building activities in the minority and medically underserved communities



National Institute
on Minority Health
and Health Disparities

Racial and Ethnic Approaches to Community Health (REACH)

- Awards grants from the Centers for Disease Control (CDC)
- States, local health departments, universities and nonprofit groups
- To implement community-focused interventions to reduce specific neighborhood-based disparities



Private Foundations and Providers

- Cultural Quality Collaborative (Hopkins)
- Kaiser Family Foundation
- Alliance to Reduce Disparities in Diabetes (Merck)
- Several others

What is APMA doing?

- 2012 APMA President Joseph M. Caporusso, DPM, and the APMA Board of Trustees initiated a taskforce on Health-Care Disparities
- Found several areas where APMA, podiatrists, and the profession can be a part of the elimination of health and health-care disparities
- Diabetic Foot

Committee to End Health-Care Disparities

- Subcommittee of Public Health and Preventive Podiatric Medicine Committee
 - Chair: Crystal M. Holmes, DPM
 - Evaluates health-care disparities within podiatric medicine
 - Increases awareness of health-care disparities within our profession
 - Works in collaboration with other groups to eliminate health-care disparities

Why should we get involved?

- Moral, ethical
- Improves health care for the entire community
- Eliminates health care waste
- Podiatric physicians can have the greatest impact, and our profession can be leaders in this area of eliminating health-care disparities

IN SUMMARY

- Health Care Disparities are data driven.
 - What is done with the data?
 - What can we do?
 - Pay attention to your demographics
 - Recognize disparity
 - Modify treatment protocol
 - Document modification
-



ANY QUESTIONS?

THANK YOU