WHY WE CAN’T WAIT:
The Moral Imperative for Addressing Healthcare Disparities Under Healthcare Reform

A lecture delivered to the National Minority Quality Forum
April 20, 2010
Washington, D.C.
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Disclosure of Relevant Financial Relationships

- Grants and other financial support:
Pfizer, AstraZeneca, Forest, CV Therapeutics
- Speakers Bureau and Advisory Board:
Pfizer, AstraZeneca, Forest, CV Therapeutics
WHERE DO WE STAND?
HOW FAR HAVE WE COME?
WHERE CAN HEALTHCARE REFORM LAW TAKE US?
WHAT IS THE IMPACT ON YOU?
“Of all the forms of inequality, injustice in health is the most shocking and inhumane.”

Dr. Martin Luther King, Jr.
A POETIC INTRODUCTION TO THE QUANDARY OF ELIMINATING HEALTHCARE DISPARITIES

Upon this gifted age, in its dark hour,
Rains from the sky a meteoric shower
Of facts…they lie unquestioned, uncombined,
Wisdom enough to leech us of our ill
Is daily spun, but there exists no loom
To weave it into fabric……..

“Huntsman, What Quarry?”
Edna St. Vincent Millay
HEALTHY PEOPLE 2010

• TOOL FOR ASSESSING HEALTH OF NATION IN 21ST CENTURY
• CONTAINS 467 OBJECTIVES AND 28 FOCUS AREAS
• REPRESENTS THE 3RD ITERATION OF A 10-YEAR HHS PLAN OF HEALTH OBJECTIVES FOR THE NATION (PREVIOUS: 1979, 1990)
• TWO OVERARCHING GOALS:
  --INCREASE THE QUALITY AND QUANTITY OF HEALTHY LIFE
  --ELIMINATE HEALTHCARE DISPARITIES
LEADING HEALTH INDICATORS

- PHYSICAL ACTIVITY
- OVERWEIGHT AND OBESITY
- TOBACCO USE
- SUBSTANCE ABUSE
- RESPONSIBLE SEXUAL BEHAVIOR
- MENTAL HEALTH
- INJURY AND VIOLENCE
- ENVIRONMENTAL QUALITY
- IMMUNIZATION
- ACCESS TO HEALTH CARE
2007 National Healthcare Disparities Report (NHDR)

Progress is being made, but many of the biggest gaps remain

Released March 3, 2008
Origin of NHDR

- Health and Human Services Secretary required to submit annual report to Congress:
  - National trends in health care quality (National Healthcare Quality Report, or NHQR)
  - Prevailing disparities in health care delivery as it relates to racial factors and socioeconomic factors in priority populations (NHDR)

Mandated by Congress in Healthcare Research and Quality Act (PL. 106-129)
# Relationship Between NHDR and NHQR

<table>
<thead>
<tr>
<th>NHDR</th>
<th>NHQR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Snapshot of disparities in health care in America</td>
<td>Snapshot of quality of health care in America</td>
</tr>
<tr>
<td>Quality + access</td>
<td>Quality</td>
</tr>
<tr>
<td>Safety, effectiveness, timeliness, patient centeredness + equity</td>
<td>Safety, effectiveness, timeliness, patient centeredness</td>
</tr>
<tr>
<td>Variation across populations</td>
<td>Variation across States</td>
</tr>
</tbody>
</table>
NHQR and NHDR Goals

• Provide a snapshot of health care delivery
  – 41 core measures of quality and access
  – 211 total measures

• Indicate the biggest gaps in care

• Show National and State trends

• Tell us how we can reach our goals

• Help align measures across public and private quality initiatives
## NHQR and NHDR Framework

<table>
<thead>
<tr>
<th>Consumer Perspectives on Health Care Needs</th>
<th>Components of Health Care Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Safety</td>
</tr>
<tr>
<td>Staying healthy</td>
<td></td>
</tr>
<tr>
<td>Getting better</td>
<td></td>
</tr>
<tr>
<td>Living with illness or disability</td>
<td></td>
</tr>
<tr>
<td>Coping with end-of-life matters</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Institute of Medicine Committee. “Envisioning the National Health Care Quality Report,” 2001
NHQR/NHDR Content and Organization

- Effectiveness
  - Cancer
  - Diabetes
  - End Stage Renal Disease (ESRD)
  - Heart Disease
  - HIV and AIDS
  - Maternal and Child Health
  - Mental Health and Substance Abuse
  - Nursing Home, Home Health, and Hospice Care
- Patient Safety
- Timeliness
- Patient Centeredness
  - Access to Health Care
  - Priority Populations

*Also includes a chapter on Efficiency*
Total = 296.4 million

Data excludes Puerto Rico, Guam, U.S. Virgin Islands, Northern Marina Islands.
Health Care Quality

• Disparities in health care quality are staying the same or increasing

n=number of core measures
Access to Health Care

• Disparities in access to care are staying the same or increasing
NHDR Findings

- Over 60% of disparities in quality of care have stayed the same or worsened for Blacks, Asians, and poor populations.
- Nearly 60% of disparities have stayed the same or worsened for Hispanics.
- For Blacks, Asians, Hispanics, and poor populations, disparities in about half the core measures of access to care are lessening.
## Core Measures That Showed Reduction in Disparities, 2000-2001 to 2004-2005

<table>
<thead>
<tr>
<th>Group</th>
<th>Measure</th>
<th>Relative rate for earliest year in NHDR</th>
<th>Relative rate for most recent year in NHDR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black compared with White</td>
<td>Hemodialysis patients with adequate dialysis (urea reduction ratio 65% or greater)</td>
<td>1.29</td>
<td>1.08</td>
</tr>
<tr>
<td></td>
<td>New AIDS cases per 100,000 population age 13 and over</td>
<td>10.4</td>
<td>10.0</td>
</tr>
<tr>
<td></td>
<td>Children 19-35 months who received all recommended vaccines</td>
<td>1.31</td>
<td>1.14</td>
</tr>
<tr>
<td>Asian compared with White</td>
<td>Persons who have a usual primary care provider</td>
<td>1.40</td>
<td>1.13</td>
</tr>
<tr>
<td></td>
<td>Children 19-35 months who received all recommended vaccines</td>
<td>1.21</td>
<td>1.12</td>
</tr>
<tr>
<td></td>
<td>Tuberculosis patients who completed a curative course of treatment within 12 months of initiation of treatment</td>
<td>1.09</td>
<td>.97</td>
</tr>
<tr>
<td>AI/AN compared with White</td>
<td>High-risk short-stay nursing home residents who developed pressure sores</td>
<td>1.15</td>
<td>1.06</td>
</tr>
<tr>
<td></td>
<td>High-risk long-stay nursing home residents who developed pressure sores</td>
<td>1.17</td>
<td>1.07</td>
</tr>
</tbody>
</table>
Core Measures That Showed Reduction in Disparities, 2000-2001 to 2004-2005

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</tr>
</thead>
<tbody>
<tr>
<td>Hispanic compared with Non-Hispanic White</td>
<td>Adult perforated appendix per 1,000 admissions with appendicitis</td>
<td>1.06</td>
<td>1.01</td>
</tr>
<tr>
<td></td>
<td>Adults who can sometimes or never get care for illness or injury as soon as wanted</td>
<td>2.00</td>
<td>1.62</td>
</tr>
<tr>
<td></td>
<td>Children 19-35 months who received all recommended vaccines</td>
<td>1.28</td>
<td>1.18</td>
</tr>
<tr>
<td></td>
<td>New AIDS cases per 100,000 population age 13 and over</td>
<td>3.64</td>
<td>3.52</td>
</tr>
<tr>
<td></td>
<td>Pregnant women receiving prenatal care in first trimester</td>
<td>2.12</td>
<td>2.03</td>
</tr>
<tr>
<td>Poor compared with High income</td>
<td>Adult perforated appendix per 1,000 admissions with appendicitis</td>
<td>3.47</td>
<td>1.10</td>
</tr>
<tr>
<td></td>
<td>Persons under age 65 with health insurance</td>
<td>6.15</td>
<td>4.86</td>
</tr>
</tbody>
</table>
### Three Largest Disparities in Health Care Quality for Selected Groups: 2005 Versus 2007 NHDR

<table>
<thead>
<tr>
<th>Group</th>
<th>Measure</th>
<th>2005 NHDR</th>
<th>Relative rate</th>
<th>Measure</th>
<th>2007 NHDR</th>
<th>Relative rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>New AIDS cases per 100,000 population age 13 and over</td>
<td>10.4</td>
<td></td>
<td>New AIDS cases per 100,000 population age 13 and over</td>
<td>10.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital admissions for pediatric asthma per 100,000 population ages 2-17</td>
<td>4.0</td>
<td></td>
<td>Hospital admissions for pediatric asthma per 100,000 population ages 2-17</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent of patients who left the emergency department without being seen</td>
<td>1.9</td>
<td></td>
<td>Hospital admissions for lower extremity amputations in patients with diabetes per 100,000 population</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>Persons age 18 or older with serious mental illness who did not receive mental health treatment or counseling in the past year</td>
<td>1.6</td>
<td></td>
<td>Composite: Adults who reported poor communication with health providers</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adults who can sometimes or never get care for illness or injury as soon as wanted</td>
<td>1.6</td>
<td></td>
<td>Long-stay nursing home residents who were physically restrained</td>
<td>1.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adults age 65 and over who did not ever receive pneumococcal vaccination</td>
<td>1.5</td>
<td></td>
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</tr>
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<tbody>
<tr>
<td><strong>AI/ANs</strong></td>
<td>Women not receiving prenatal care in the first trimester</td>
<td>2.1</td>
<td></td>
<td>Women not receiving prenatal care in the first trimester</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Composite: Adults who reported poor communication with health providers</td>
<td>1.8</td>
<td></td>
<td>Composite: Adults who reported poor communication with health providers</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children ages 2-17 with no advice about physical activity</td>
<td>1.3</td>
<td></td>
<td>Women age 40 and over who reported they did not have a mammogram within the past 2 years</td>
<td>1.8</td>
<td></td>
</tr>
<tr>
<td><strong>Hispanic</strong></td>
<td>New AIDS cases per 100,000 population age 13 and over</td>
<td>3.7</td>
<td></td>
<td>New AIDS cases per 100,000 population age 13 and over</td>
<td>3.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adults who can sometimes or never get care for illness or injury as soon as wanted</td>
<td>2.0</td>
<td></td>
<td>Hospital admissions for lower extremity amputations in patients with diabetes per 100,000 population</td>
<td>2.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Composite: Children whose parents reported poor communication with their health providers</td>
<td>1.8</td>
<td></td>
<td>Women not receiving prenatal care in the first trimester</td>
<td>2.0</td>
<td></td>
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<th>2007 NHDR</th>
<th>Relative rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>Composite: Children whose parents reported poor communication with their health providers</td>
<td>3.3</td>
<td></td>
<td>Composite: Children whose parents reported poor communication with their health providers</td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adults who can sometimes or never get care for illness or injury as soon as wanted</td>
<td>2.3</td>
<td></td>
<td>Adults who can sometimes or never get care for illness or injury as soon as wanted</td>
<td>2.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children ages 2-17 who did not have a dental visit</td>
<td>2.0</td>
<td></td>
<td>Women age 40 and over who reported they did not have a mammogram within the past 2 years</td>
<td>2.1</td>
<td></td>
</tr>
</tbody>
</table>
Uninsurance Is a Major Barrier To Reducing Disparities

• Uninsured individuals do worse than privately insured individuals on almost 90% of quality measures and on all access measures

CRM=core report measures
Poverty Status of the Nonelderly Population by Race/Ethnicity, 2005

Non-Poor (200% + FPL)
Near Poor (100% - 199% FPL)
Poor (<100%FPL)

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Non-Poor</th>
<th>Near Poor</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>White (Non-Hispanic)</td>
<td>74%</td>
<td>14%</td>
<td>12%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>42%</td>
<td>29%</td>
<td>29%</td>
</tr>
<tr>
<td>African American (Non-Hispanic)</td>
<td>46%</td>
<td>33%</td>
<td>21%</td>
</tr>
<tr>
<td>Asian Only</td>
<td>68%</td>
<td>16%</td>
<td>17%</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>43%</td>
<td>23%</td>
<td>34%</td>
</tr>
<tr>
<td>Two or More Races</td>
<td>59%</td>
<td>20%</td>
<td>21%</td>
</tr>
</tbody>
</table>

Nonelderly 166.6 million  40.8 million  32.6 million  11.8 million  1.5 million  4.2 million

NOTE: Individuals who reported more than one race group were categorized as “Two or more races.”
Nonelderly includes all individuals under age 65. FPL = Federal Poverty Level. The FPL for a family of four in 2005 was $19,971.
Fair or Poor Health, by Race/Ethnicity, 2004

Percent with fair or poor health

8% White (Non-Hispanic) 13% Hispanic 15% African American (Non-Hispanic) 9% Asian Only* 17% American Indian/Alaska Native 13% Two or More Races

NOTES: Respondents assessed their health status as excellent, very good, good, fair, or poor. *The sample size for Native Hawaiian/Pacific Islander was not large enough for reliable estimates.
SOURCE: Health, United States, 2006, Table 60.
Fair or Poor Health, by Race/Ethnicity and Income, 2004

Percent with fair or poor health

- **White, Non-Hispanic**
  - < 100% of Poverty: 21%
  - 100 – 199% of Poverty: 14%
  - 200% + of Poverty: 6%

- **Hispanic**
  - < 100% of Poverty: 20%
  - 100 – 199% of Poverty: 15%
  - 200% + of Poverty: 9%

- **African American, Non-Hispanic**
  - < 100% of Poverty: 26%
  - 100 – 199% of Poverty: 17%
  - 200% + of Poverty: 10%

**NOTES:** Respondents assessed their health status as excellent, very good, good, fair or poor. The federal poverty level for a family of four in 2004 was $19,307 (http://www.census.gov/hhes/www/poverty/threshld/thresh04.html).

**DATA:** National Center for Health Statistics, National Health Interview Survey, 2004.

**SOURCE:** Health, United States, 2006, Table 60.
Mortality Ratios, by Age and Race/Ethnicity, 2003

NOTE: These data compare the mortality rate of each racial/ethnic group to that of Asian/Pacific Islanders, the group with the lowest mortality rates at each age.
SOURCE: Kaiser Family Foundation, Key Facts: Race, Ethnicity and Medical Care, 2007, Figure 10.
Infant Mortality Rates for Mothers Age 20+, by Race/Ethnicity and Education, 2001-2003

Infant deaths per 1,000 live births

<table>
<thead>
<tr>
<th>Less than High School</th>
<th>Infant deaths per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American (Non-Hispanic)</td>
<td>15.1</td>
</tr>
<tr>
<td>American Indian/Alaska Native White (Non-Hispanic)</td>
<td>10.7</td>
</tr>
<tr>
<td>Asian and Pacific Islander Hispanic</td>
<td>9.2</td>
</tr>
<tr>
<td>White (Non-Hispanic)</td>
<td>5.3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High School</th>
<th>Infant deaths per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American (Non-Hispanic)</td>
<td>13.4</td>
</tr>
<tr>
<td>American Indian/Alaska Native White (Non-Hispanic)</td>
<td>9.2</td>
</tr>
<tr>
<td>Asian and Pacific Islander Hispanic</td>
<td>6.5</td>
</tr>
<tr>
<td>White (Non-Hispanic)</td>
<td>5.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>College+</th>
<th>Infant deaths per 1,000 live births</th>
</tr>
</thead>
<tbody>
<tr>
<td>African American (Non-Hispanic)</td>
<td>11.5</td>
</tr>
<tr>
<td>American Indian/Alaska Native White (Non-Hispanic)</td>
<td>7.0</td>
</tr>
<tr>
<td>Asian and Pacific Islander Hispanic</td>
<td>3.9</td>
</tr>
<tr>
<td>White (Non-Hispanic)</td>
<td>4.6</td>
</tr>
</tbody>
</table>

SOURCE: Kaiser Family Foundation, Key Facts: Race, Ethnicity and Medical Care, 2007, Figure 9.
Health Insurance Coverage
Health Insurance Coverage of the Nonelderly Population by Race/Ethnicity, 2005

NOTE: Nonelderly includes individuals up to age 65. “Other Public” includes Medicare and military-related coverage; SCHIP is included in Medicaid.
### Health Insurance Coverage of Children, by Race/Ethnicity, 2005

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Uninsured</th>
<th>Medicaid/Other Public</th>
<th>Employer</th>
<th>Private Non-Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>8%</td>
<td>19%</td>
<td>68%</td>
<td>6%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>22%</td>
<td>40%</td>
<td>36%</td>
<td>2%</td>
</tr>
<tr>
<td>African American</td>
<td>13%</td>
<td>46%</td>
<td>39%</td>
<td>2%</td>
</tr>
<tr>
<td>Asian</td>
<td>13%</td>
<td>18%</td>
<td>65%</td>
<td>5%</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>28%</td>
<td>35%</td>
<td>35%</td>
<td>3%</td>
</tr>
</tbody>
</table>

**NOTES:** Nonelderly includes individuals up to age 65. “Other public” includes Medicare and military-related coverage, SCHIP is included in Medicaid. DATA: March 2005 Current Population Survey. SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates.
Uninsured Rates Among Workers by Race/Ethnicity, 2005

- White: 14%
- Hispanic: 40%
- African American: 23%
- Asian and Pacific Islander: 19%
- American Indian/Alaska Native: 32%
- Two or More Races: 20%

NOTE: Workers includes all workers ages 18 to 64.
Medicare Beneficiaries Age 65 and Older, by Race/Ethnicity, 1999 and 2030

NOTE: “Other” includes Asians or Pacific Islanders, American Indians, or other race not of Hispanic ancestry. Numbers may not add up to 100% due to rounding.
SOURCE: Kaiser Family Foundation, Key Facts: Race, Ethnicity and Medical Care, 2003, Figure 13.
Access to Preventive and Primary Care
No Usual Source of Health Care: Adults 18-64, by Race/Ethnicity, 2003-2004

Percent without a usual source of care

- White (Non-Hispanic): 15%
- Hispanic: 31%
- African American (Non-Hispanic): 18%
- Asian Only*: 19%
- American Indian/Alaska Native: 21%
- Two or More Races: 18%

NOTE: * The sample size for Native Hawaiian/Pacific Islander was not large enough for reliable estimates.
SOURCE: Health, United States, 2006, Table 77.
No Health Care Visits in the Past Year, by Race/Ethnicity and Poverty Status, 2004

Percent distribution

< 100% of Poverty

200% + of Poverty

SOURCE: Kaiser Family Foundation, Key Facts: Race, Ethnicity and Medical Care, 2007, Figure 29.
Late or No Prenatal Care, by Race/Ethnicity, 1990 and 2004

Percent of live births

<table>
<thead>
<tr>
<th></th>
<th>1990</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>3%</td>
<td>11%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>12%</td>
<td>6%</td>
</tr>
<tr>
<td>African American</td>
<td>13%</td>
<td>5%</td>
</tr>
<tr>
<td>API</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>AI/AN</td>
<td>3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Disparities in Specialty Medical Care
Receipt of Recommended Tests for Diabetics by Race/Ethnicity, 2003

NOTES: Data show share of adults with diabetes who received test within past year. Data for Asians and Pacific Islanders and American Indian/Alaska Natives not presented because data do not meet criteria for statistical reliability, quality, or confidentiality.
DATA: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey.
Hospital Admissions Rates among Diabetics by Race/Ethnicity, 2003

NOTE: Data are for adult population only and reflect admissions for uncontrolled diabetes without complications. Data on complications do not include obstetric and neonatal admissions and transfers from other institutions.


New AIDS Cases and HIV-Infection Deaths by Race/Ethnicity

Changes in Quality of Care Disparities over Time: Summary by Race/Ethnicity

- **Black vs. White (n=40)**: 58% decreasing, 42% increasing
- **Asian vs. White (n=25)**: 52% decreasing, 48% increasing
- **American Indian/Alaska Native vs. White (n=16)**: 50% decreasing, 50% increasing
- **Hispanic vs. Non-Hispanic White (n=34)**: 59% decreasing, 41% increasing

**NOTES:** “Decreasing” means disparity is becoming smaller over time; “increasing” means disparity becoming larger over time. Data on all measures are not available for all groups; “n” refers to the number of measures on which the groups were compared. Totals may not add to 100% due to rounding. Time period differs by measure and includes oldest and newest years of available data.

**DATA:** Agency for Healthcare Quality and Research.

A FEW SPECIFIC DISPARITIES

- 48% OF BLACKS SUFFER CHRONIC DISEASES, WHITES 39%
- 7 OF 10 BLACKS ARE OVERWEIGHT OR OBESE
- BLACKS ARE MORE LIKELY TO DIE FROM CANCER. BLACK MEN HAVE 50% MORE PROSTATE CANCER
- DIABETES STRIKES 15% OF BLACKS, 14% OF HISPANICS, 18% OF AMERICAN INDIANS, ONLY 8% OF WHITES
- HIV STRIKES BLACKS 9 TIMES MORE THAN WHITES
- COLORECTAL CA SCREENING: WHITES 57%, BLACKS 47%, HISPANICS 39%
- LEG AMPUTATIONS: BLACKS 5X MORE THAN WHITES, 4.17/1000 VS 0.88/1000. LOUISIANA HAS HIGHEST RATE
- WOMEN OF COLOR FARE WORSE THAN WHITE WOMEN IN ALL STATES
Perceptions of Disparities in Health Care

Generally speaking, how often do you think our health care system treats people unfairly based on...

### Percent Saying “Very/Somewhat Often”

<table>
<thead>
<tr>
<th>Perception</th>
<th>Doctors</th>
<th>Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not they have insurance</td>
<td>72%</td>
<td>70%</td>
</tr>
<tr>
<td>How well they speak English</td>
<td>43%</td>
<td>58%</td>
</tr>
<tr>
<td>What their race or ethnic background is</td>
<td>29%</td>
<td>47%</td>
</tr>
<tr>
<td>Whether they are male or female</td>
<td>15%</td>
<td>27%</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation, National Survey of Physicians, March 2002 (conducted March-October 2001); Survey of Race, Ethnicity and Medical Care: Public Perceptions and Experiences, October 1999 (Conducted July – Sept., 1999)
THE SEVEN DEADLY SINS THAT LEAD TO HEALTHCARE DISPARITIES

• 1. Treating patients in a racist manner.
• 2. Showing disrespect for patients’ cultural beliefs.
• 3. Intolerance of the patient’s limited English proficiency (LEP).
• 4. Failure to use proper expertise and knowledge in addressing the patient’s problems.
• 5. Lack of using the utmost professionalism in patient encounters.
• 6. Disregarding the patient’s HIPAA rights to privacy and confidentiality.
• 7. Treating the patient as a financial commodity based on lack of private insurance, etc.
What More Can Be Done To Eliminate Health Disparities?

- Expand Knowledge Base (Collection and Reporting of Data By Race/Ethnicity)
- Improve Sources of Health Financing and Care
- Greater Integration of Efforts Across the Public and Private Sector
- Increase Public and Provider Awareness
- Legislation for Elimination of Healthcare Disparities
Conclusion

• **Access to care**
  – One of many contributors to poor health outcomes of people of color, yet important to address

• **Personal characteristics (e.g. race/ethnicity)**
  – Should not adversely affect care and warrants

• **Taking Action**
  – Need to develop effective strategies
Related Resources

• Key Facts: Race, Ethnicity, and Medical Care
  http://www.kff.org/minorityhealth/6069.cfm

• Kaiser Health Disparities Report - A Weekly Look at Race, Ethnicity and Health
  http://www.kaisernetwork.org/Daily_reports/rep_disparities.cfm

• National Healthcare Disparities Report
  http://www.ahrq.gov/qual/nhdr06/nhdr06.htm

• Today’s Topics in Health Disparities
  www.kaisernetwork.org/todaystopics

• National Center on Minority Health and Health Disparities
  http://ncmhd.nih.gov/

• Health Resources and Services Administration (HRSA) Office of Minority Health
  http://ask.hrsa.gov/Minority.cfm

• Indian Health Service
  http://www.ihs.gov/
Life Expectancy of black males is 6.2 years less than that of white males and black females 4.5 years less than their white counterparts.
Progress Report

Source:
Agency for healthcare research and quality 2007 National Disparity report
Barriers in access to quality health care leading to disparities

**System**
- Lack of health insurance
- Availability of providers
- Type of providers and their resources
- Location of services
- Organization of care

**Provider**
- Knowledge
- Attitudes and bias
- Lack of technical or interpersonal skills
- Communication
- Decision-making (participatory) style
- Patient-centered care
- Physician social concordance with patient

**Patient**
- Knowledge
- Attitudes
- Cultural beliefs
- Health behaviors
- Language
- Health Literacy
- Social support
- Religious beliefs
- Fear
- Self-efficacy
- Preferences
- Psychosocial
- Socioeconomic status
- Trust
Merits of eliminating racial disparities
Merits of eliminating racial disparities

From 1991-2000: comparison between lives saved with medical advances and those that could have been saved by eliminating racial disparities

- Medical advances saved 177,000 deaths
- Eliminating disparities could have saved 886,000 deaths
- What if we were equal? (Satcher)
Where’s the Data?

Studies Describing Racial Disparities in Cardiovascular Disease

>2500

Studies Describing Interventions to eliminate disparities 70

27 hypertension, 9 lipids, 18 tobacco use, 8 physical inactivity, and 7 heart failure. 1 post-myocardial infarction
Eliminating Disparities in Cardiovascular Health
Six Strategic Imperatives and a Framework for Action

George A. Mensah, MD

Abstract—Disparities in cardiovascular health are among the most serious public health problems in the United States today. Despite the remarkable declines in cardiovascular mortality observed nationally over the last 3 decades, many population subgroups defined by race, ethnicity, gender, socioeconomic status, educational level, or geography show striking, and often widening, disparities in cardiovascular health. The pervasive nature of these disparities and compelling evidence of the adverse impact they have on clinical outcomes and quality of life have been well documented. The elimination of these disparities is 1 of the 2 overarching goals of the Healthy People 2010 national public health agenda; however, few publications provide guidance on what actions to take. In this review, 6 strategic imperatives within a framework for action are presented. Other key elements of the framework include 10 focal areas and 6 major settings within which the framework calls for accelerated interventions to eliminate disparities in cardiovascular health. Success in this endeavor will require innovative and comprehensive interventions built on a foundation of sound clinical and public health science. Strategic partnerships with communities, community-based organizations, state and local governments, and public and private partners from both health and nonhealth sectors are essential. Additionally, investment in local-level disparities surveillance, community-based participatory research, and development of a diverse clinical and public health workforce will be invaluable. (Circulation. 2005;111:1332-1336.)

Key Words: population ■ ethnic groups ■ prevention ■ cardiovascular diseases
Framework for eliminating disparities in cardiovascular health

Mensah, G. A. Circulation 2005;111:1332-1336
Recommendations for reducing disparities

A. Strategic imperatives
   1. Accelerate health impact in disparate populations
   2. Advance policy and systems change
   3. Form strategic multidisciplinary partnerships
   4. Expand community-based participatory research and research translation
   5. Collect healthcare data by race, ethnicity, and disparities indicators
   6. Ensure a diverse clinical and public health workforce
HEALTHCARE SYSTEM REFORM

• Promote the consistency and equity of health care delivery by promoting the use of evidence based guidelines (QI initiatives)

• Structure payment systems to provide adequate financial resources and supply of services for minority patients

• Eliminate provider incentives that promote disparities
Segregated healthcare

Disparities in Health Care Are Driven by Where Minority Patients Seek Care

Examination of the Hospital Quality Alliance Measures

Romana Hasnain-Wynia, PhD; David W. Baker, MD, MPH; David Nerenz, PhD; Joe Feinglass, PhD; Anne C. Beal, MD, MPH; Mary Beth Landrum, PhD; Raj Behal, MD, MPH; Joel S. Weissman, PhD

Concentration and Quality of Hospitals That Care for Elderly Black Patients

Ashish K. Jha, MD, MPH; E. John Orav, PhD; Zhonghe Li, MA; Arnold M. Epstein, MD, MA

Primary Care Physicians Who Treat Blacks and Whites

Peter B. Bach, M.D., M.A.P.P., Hoangmai H. Pham, M.D., M.P.H., Deborah Schrag, M.D., M.P.H., Ramsey C. Tate, B.S., and J. Lee Hargraves, Ph.D.
Epidemiology

Mortality After Acute Myocardial Infarction in Hospitals That Disproportionately Treat Black Patients

Jonathan Skinner, PhD; Amitabh Chandra, PhD; Douglas Staiger, PhD; Julie Lee, PhD; Mark McClellan, MD, MPA, PhD

Conclusions—Risk-adjusted mortality after AMI is significantly higher in US hospitals that disproportionately serve blacks. A reduction in overall mortality at these hospitals could dramatically reduce black-white disparities in healthcare outcomes. (Circulation. 2005;112:2634-2641.)
HOSPITAL CARE: WILL QUALITY IMPROVEMENT HELP?

• If hospitals that care for Blacks and Hispanics are poor quality, targeted Quality Improvement will help

• The problem is………… It’s not happening

• Many of the recent quality improvement initiatives (GAP, CRUSADE, AHA GWTG) have included hospitals that care primarily for minorities
Reform: *Healthcare Systems*

- Promote the consistency and equity of health care delivery by promoting the use of evidence based guidelines (QI initiatives)
- Structure payment systems to provide adequate financial resources and supply of services for minority patients
- Eliminate provider incentives that promote disparities
A Fresh Approach to Health Care in the United States: Improved and Expanded Medicare for All

Conyers proclamation

• US spends more than two times in health care costs than the next closest nation (17% of GDP)
• Ranks 37th in overall quality of healthcare
• Over 40 million uninsured and 20 million underinsured
• 180,000 deaths annually attributed to lack of insurance
Conyers proposal

• Founded the Congressional Universal Health Care Task Force

• Eliminate privatized HMO insurance driven health care (20-30% overhead) save 100 billion dollars

• Medicare for all plan (2-3% overhead) insurance for all; no deductibles or co-pays patient choice for provider
Reform: *Healthcare Systems*

- Promote the consistency and equity of health care delivery by promoting the use of evidence based guidelines (QI initiatives)
- Structure payment systems to provide adequate financial resources and supply of services for minority patients
- Eliminate provider incentives that promote disparities
Pay for Performance

Outcomes, Health Policy, and Managed Care

Potential unintended financial consequences of pay-for-performance on the quality of care for minority patients

Amrita M. Karve, BS,\textsuperscript{a} Fang-Shu Ou, MS,\textsuperscript{a} Barbara L. Lytle, MS,\textsuperscript{a} and Eric D. Peterson, MD, MPH\textsuperscript{a,b} Durham, NC

American Heart Journal 2008
Performance by proportion of AA patients treated

Figure 2

Composite performance scores by condition. Mean composite performance scores ± SD for AMI, CAP, and HF by % AA patients. P < .01 for AMI and CAP, P = .06 for HF.
Reform: Physician level

• Provide financial incentives to practices that reduce barriers and encourage adherence to evidence based guidelines
• Support the use of community health workers and implement multidisciplinary treatment and preventive care teams
• Provide culturally and linguistically appropriate resources to communities
Impact of a Community-Based Multiple Risk Factor Intervention on Cardiovascular Risk in Black Families With a History of Premature Coronary Disease

Diane M. Becker, ScD, MPH; Lisa R. Yanek, MPH; Wallace R. Johnson, Jr, MD; Diane Garrett; Taryn F. Moy, MS; Stasia Stott Reynolds, MD; Roger S. Blumenthal, MD; Dhananjay Vaidya, MD, PhD; Lewis C. Becker, MD

Background—Black subjects with a family history of premature coronary heart disease (CHD) have a marked excess risk, yet barriers prevent effective risk reduction. We tested a community-based multiple risk factor intervention (community-based care [CBC]) and compared it with “enhanced” primary care (EPC) to reduce CHD risk in high-risk black families.
Intervention

- Community Based Care (CBC) care given by a nurse practitioner and community health worker

- Enhanced Primary Care (EPC)
CBC Intervention
Sibs randomized to CBC received care in 1 nonclinical site in the community that was designed by a community advisory panel. The site was easily accessible by bus lines and subway and was within walking distance for many sibs. The suite consisted of a comfortable conference room for counseling; a clinical room for phlebotomy and physical examination; an exercise room containing a treadmill, weights, Thera-Band resistive exercise equipment, and a choice of music; and a living room with a children’s play area. The original purpose of the exercise room was to evaluate shifts in exercise blood pressure with therapy and to expose people to the physical “experience” of exercise in a safe environment. Appointments were not necessary, and the Family Heart Center was open from 9 AM until 5 PM Monday through Friday, with evenings and Saturday appointments available if requested.
COMMUNITY INTERVENTION RESULTS

TABLE 2. Risk Factors, Global Risk, Diet, Exercise, and Medications by Group at Baseline and Follow-Up*

<table>
<thead>
<tr>
<th></th>
<th>CBC Group (n=196)</th>
<th>EPC Group (n=168)</th>
<th>( P^+ )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>1 Year</td>
<td>Baseline</td>
</tr>
<tr>
<td>LDL-C, mmol/L</td>
<td>3.59±1.0</td>
<td>3.06±1.0</td>
<td>3.51±1.0</td>
</tr>
<tr>
<td>TG, mmol/L</td>
<td>1.47±1.1</td>
<td>1.35±1.0</td>
<td>1.37±0.72</td>
</tr>
<tr>
<td>HDL-C, mmol/L</td>
<td>1.40±0.42</td>
<td>1.40±0.41</td>
<td>1.39±0.45</td>
</tr>
<tr>
<td>SBP, mm Hg</td>
<td>139±16</td>
<td>130±14</td>
<td>137±16</td>
</tr>
<tr>
<td>DBP, mm Hg</td>
<td>89±10</td>
<td>84±9</td>
<td>86±11</td>
</tr>
<tr>
<td>BMI, kg/m²</td>
<td>31.9±6.3</td>
<td>31.8±6.4</td>
<td>31.1±6.7</td>
</tr>
<tr>
<td>Glucose, mmol/L</td>
<td>6.10±2.9</td>
<td>5.97±2.7</td>
<td>5.77±2.5</td>
</tr>
<tr>
<td>Energy expenditure, mJ/d</td>
<td>10.4±3.0</td>
<td>10.8±3.0</td>
<td>10.8±3.4</td>
</tr>
<tr>
<td>Percent current smokers</td>
<td>37</td>
<td>31</td>
<td>43</td>
</tr>
<tr>
<td>Percent taking antihypertensive agents</td>
<td>35</td>
<td>52</td>
<td>32</td>
</tr>
<tr>
<td>Percent taking lipid-lowering agents</td>
<td>4</td>
<td>36</td>
<td>8</td>
</tr>
</tbody>
</table>
Community Intervention Results

- BP Control: N=249, P=0.0004
- LDL-C Control: N=225, P<0.0001
- Smoking Cessation: N=144, P=0.06

**********
Reform: Patient Level

- Implement patient education programs to increase patients knowledge on how to access care and participate in medical decision making
- Endorse patient navigator programs that will assist minority patients in accessing care, obtaining financial resources, and following through with treatment plans
Reform: Patient Level

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- Endorse patient navigator programs that will assist minority patients in accessing care, obtaining financial resources, and following through with treatment plans
Introducing the **Patient Support Coordinator Program**

A dedicated, central point of contact helping providers and patients who rely on Celgene products

Trained professionals providing personal assistance concerning:

- Reimbursement assistance, insurance claims, and appeals
- Medicare Part D issues
- Locating co-pay assistance programs and services
- Identifying pharmacies that are registered to dispense Celgene products
- Determining the status of a prescription
- Inquiries regarding Celgene’s patient assistance program
- Providing information regarding Celgene products and their restricted distribution programs (RevAssist® or S.T.E.P.S.®) or appropriate contacts for other questions
Social Reform

- Barack Obama, President of the United States.
- MORE WORK TO BE DONE

The intersection of race and socioeconomic status is undeniable.
1903, The problem of health in the 20th century is the color line "with improved sanitary conditions, education and better economic conditions."
Conclusions

Given the insidious nature of health care disparities in our society, interventions to reduce health disparities must encompass all settings including where we live, work, play and worship.

Partnerships with community organizations, health policy agencies, professional societies, and academic leaders are necessary to make significant strides in ending health care disparities.
Summary

• Access to care is paramount
• Guideline Based Care will help if used consistently in all health care delivery venues
• Interventions that improve patient and physician relationships are necessary
• Social reform that does not limit economic opportunities by the color of a person’s skin
• We must recognize that THE WORLD IS FLAT (Economist Thomas Friedman) and that there needs to be a shift from vertical to horizontal relationships between entities involved in healthcare
Hebrews 11:1

• *Faith* is the substance of things hoped for, and the evidence of things not seen
BIBLICAL QUOTATION APPLICABLE TO ELIMINATING HEALTHCARE DISPARITIES

• “WHERE THERE IS NO VISION, THE PEOPLE PERISH.”

Proverbs 29:18
ARE OUR GOALS TOO LOFTY?

“THE BIGGEST RISK IS NOT AIMING TOO HIGH AND MISSING IT, BUT AIMING TOO LOW AND REACHING IT.”

-Michelangelo
WE MAY HAVE COME HERE ON DIFFERENT SHIPS,
BUT WE’RE ALL IN THE SAME BOAT NOW!!
CHANGE HAS COME! YES WE CAN!