Unequal Treatment 15 Years Later
Unfinished Business

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Unequal Treatment
Finding 1-1: Racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable.
Finding 2-1: Racial and ethnic disparities in healthcare occur in the context of broader historic and contemporary social and economic inequality, and evidence of persistent racial and ethnic discrimination in many sectors of American life.
Finding 3-1: Many sources - including health systems, healthcare providers, patients, and utilization managers - may contribute to racial and ethnic disparities in healthcare.
Finding 4-1: Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare. While indirect evidence from several lines of research supports this statement, a greater understanding of the prevalence and influence of these processes is needed and should be sought through research.
Finding 4-2: A small number of studies suggest that racial and ethnic minority patients are more likely than white patients to refuse treatment. These studies find that differences in refusal rates are generally small and that minority patient refusal does not fully explain healthcare disparities.
In short...

- Healthcare disparities exist
- Healthcare disparities matter
- They are part of a broad set of social disadvantages faced by minorities
- They are multifactorial
- The elephant MAY be part of the problem but we still need convincing
- Patient choice is not the problem or the solution
A controversial definition

“Despite the unprecedented explosion in scientific knowledge and the phenomenal capacity of medicine to diagnose, treat and cure disease, Blacks, Hispanics, Native American Indians and those of Asian/Pacific Islander Heritage have not benefited fully or equitably from the fruits of science or from those systems responsible for translating and using health sciences technology.”
Then what happened?
QUALITY: Through 2013, most measures of health care quality for Blacks improved

<table>
<thead>
<tr>
<th>Category</th>
<th>Improving</th>
<th>No Change</th>
<th>Worsening</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (n=179)</td>
<td>57%</td>
<td>37%</td>
<td>4%</td>
</tr>
<tr>
<td>Patient Safety (n=23)</td>
<td>106%</td>
<td>17%</td>
<td>4%</td>
</tr>
<tr>
<td>Person-Centered Care (n=18)</td>
<td>57%</td>
<td>23%</td>
<td>5%</td>
</tr>
<tr>
<td>Care Coordination (n=19)</td>
<td>60%</td>
<td>13%</td>
<td>3%</td>
</tr>
<tr>
<td>Effective Treatment (n=47)</td>
<td>43%</td>
<td>27%</td>
<td>5%</td>
</tr>
<tr>
<td>Healthy Living (n=64)</td>
<td>53%</td>
<td>23%</td>
<td>4%</td>
</tr>
</tbody>
</table>
QUALITY DISPARITIES: Through 2013, some disparities were getting smaller but most were not improving across a broad spectrum of quality measures.

<table>
<thead>
<tr>
<th>Category</th>
<th>Worsening</th>
<th>No Change</th>
<th>Improving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total (n=79)</td>
<td>13</td>
<td>64</td>
<td>22</td>
</tr>
<tr>
<td>Patient Safety (n=12)</td>
<td>1</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>Person-Centered Care (n=8)</td>
<td>1</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Care Coordination (n=15)</td>
<td>1</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Effective Treatment (n=22)</td>
<td></td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Healthy Living (n=22)</td>
<td></td>
<td>18</td>
<td>4</td>
</tr>
</tbody>
</table>
Number and percentage of quality measures for micropolitan areas with disparity at baseline for which disparities were improving, not changing, or worsening, by priority areas and access through 2014-2015

Key: n = number of measures.
Improving = Disparity is getting smaller at a rate greater than 1% per year.
No change = Disparity is not changing or is changing at a rate less than 1% per year.
Worsening = Disparity is getting larger at a rate greater than 1% per year.
Note: For each measure, the earliest and most recent data year available were analyzed through 2014-2015.
Number and percentage of quality measures for which noncore areas experienced better, same, or worse quality of care compared with reference group (large fringe metropolitan), by priority areas and access, 2014-2015

Key: n = number of measures.  
Better = Population received better quality of care than reference group.  
Same = Population and reference group received about the same quality of care.  
Worse = Population received worse quality of care than reference group.  
Note: For each measure, the most recent data year available was analyzed. These data represent 2014-2015.
Recommendations for Improvement

• General Recommendations
• Legal, Regulatory, and Policy Interventions
• Health Systems Interventions
• Patient Education and Empowerment
• Cross-Cultural Education in the Health Professions
• Data Collection and Monitoring
• Research Needs
Some things are working

Recommendation 5-1: Avoid fragmentation of health plans along socioeconomic lines.
The percentage of Americans under age 65 who lack health insurance dropped from 18 percent in 2010 to 10 percent in 2015. Data from the Agency for Healthcare Research and Quality show uninsurance rates declined among poor people, young adults, and across all races.

All races have benefited from expanded insurance

Fewer poor people were uninsured in 2015

Fewer young adults were uninsured in 2015

Source: http://www.ahrq.gov/research/findings/nhqrd/nhqdr13/index.html
Publication Date: April 2016
Figure 12. Improving: Adults ages 18-64 who were uninsured at the time of interview, by poverty status, 2010-2016, by quarter

Key: Q = quarter.
Note: For this measure, lower rates are better. Poverty categories are based on the Federal Poverty Level (FPL). Poor = below the FPL; near poor = 100% to <200% of the FPL; not poor = 200% or more of the FPL.
Some things are showing promise

Recommendation 5-10: Support the use of community health workers.
Some things need work

Recommendation 5-3: Increase the proportion of underrepresented U.S. racial and ethnic minorities among health professionals.
Figure 11. Race/Ethnicity in the RN Workforce and Total Working-Age Population

Data Sources: HRSA analysis of the ACS 2008-2010 three-year file and Census 2000 Long Form 5% sample
Figure 28. Percentage of 2015 U.S. medical school matriculants planning to practice in an underserved area by race and ethnicity.

Note: The numbers reflect the percentage responding to the following Matriculating Student Questionnaire (MSQ) question: Do you plan to work primarily in an underserved area? The totals in each race/ethnicity category include all individuals who selected that category, alone or in combination with any other category. Numbers include U.S. citizens and Permanent Residents only. Source: AAMC MSQ data, as of Aug. 1, 2016.
And in some cases, the jury is still out.

Recommendation 5-7: Structure payment systems to ensure an adequate supply of services to minority patients, and limit provider incentives that may promote disparities.
Health Policy Institute of Ohio graphics from
Where does Ohio rank?

Population health 43

Healthcare spending 28

Health value in Ohio 46

Ohio ranks in the bottom quartile on nearly 30 percent of metrics
Neighborhood is Life

Statewide life expectancy: 77.8 years

- 60 years
  Census tract: Franklin, Columbus (Franklin County)

- 61.1 years
  Census tract: McCook Field, Dayton (Montgomery County)

- 61.6 years
  Census tract: Pleasant Heights/Downtown, Steubenville (Jefferson County)

- 88.2 years
  Census tract: Montgomery, Indian Hill, Loveland and Remington (Hamilton County)

- 88.6 years
  Census tract: Shaker Heights (Cuyahoga County)

- 89.2 years
  Census tract: Slow area (Summit County)

- 88.6 years
  Census tract: Hilltop, Columbus (Franklin County)

Source: Centers for Disease Control and Prevention, U.S. Small-area Life Expectancy Estimates Project

Lowest life expectancy in Ohio
Highest life expectancy in Ohio

Nationwide Children's
When your child needs a hospital, everything matters.
Life expectancy by ZIP code

There’s a 20-year difference in life expectancy across ZIP codes in Franklin County, according to a new report by the Kirwan Institute for the Study of Race and Ethnicity at Ohio State University. Race, ethnicity and poverty likely play a role, as do neighborhood environment, genetic factors and societal experiences. Data suggests that the current structure for giving benefits to seniors based on age — most notably around the age of 65 — might simply be too late for many people.

Source: Kirwan Institute for the Study of Race and Ethnicity at Ohio State University

THE COLUMBUS DISPATCH
Too many Ohioans left behind

Without a strong foundation, not all Ohioans have the same opportunity to be healthy

- **Birth**
  - Adverse childhood experiences: 38%
  - Child poverty: 35%
  - Preschool enrollment: 28%
  - High school graduation: 29%
  - Some college: 31%

- **Adulthood**
  - Adult incarceration: 38% (out of 50)
  - Unemployment: 43%

- 112,873 black children in Ohio would not be living in poverty if gap between white and black children in Ohio was eliminated.
- 11,372 Ohioans with low incomes would graduate high school if gap between low- and high-income Ohioans was eliminated.
- 29,251 Ohioans with disabilities, ages 18-64, would be employed if gap between Ohioans with and without disabilities was eliminated.
Factors that impact health

40% Social and economic environment
30% Health behaviors
20% Clinical care
10% Physical environment

Resources are **out of balance**

Modifiable factors that influence health:

- Social and economic environment: 32
- Access to care: 18
- Healthcare system: 36
- Public health and prevention: 47
- Clinical care: 20
- Health behaviors: 30
- Physical environment: 40

Thank You!

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