

Getting to Equal: Meeting the Health Service Needs of Aging Minorities



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Questions:

- 1) Why are there differences in the treatment of minority populations?
- 2) How can we create the culturally competent workforce that we need?
- 3) What can be done to ensure appropriate levels of access and quality?

Public Health Imperative

- The proportion of older Blacks will double and the proportion of Latinos will triple by 2030
- Increasing numbers of older LGBT people (including those living with HIV/AIDS, the majority of whom are African American)
- About 4 million LGBT persons aged 65 and older by 2030
- 25% of people living with HIV/AIDS are now aged 50+



Health Status and Utilization Patterns among Racial and Ethnic Minority Older Adults

- Higher rates of disabilities, multiple chronic conditions among minorities.
- Lower rates of health services use, including utilization of prevention services.
- Older minorities may also be less likely than Whites to adhere to prescribed medications.
- As a result of delayed care, Blacks and Latinos may enter the health care system with more severe medical conditions and more preventable hospitalizations.

(AHRQ, 2006; NCHS, 2007; Crossing the Quality Chasm, IOM, 2001, Bowen 2008)



Disparities in the Health Care System

Older Black patients:

- receive poorer management of chronic medical conditions than older whites (Davis et al., 2003)
- are less likely than Whites to receive a range of medical procedures (e.g., revascularization after coronary angiography, surgical resection of early stage lung cancer, bone marrow transplants for leukemia, beta blockers for heart attack, and eye exams for diabetes)
- are less likely to have access to new procedures and other specialized and high technology services
- are more likely than Whites to rely on neighborhood health centers, outpatient hospital care, or emergency rooms for health care, whereas Whites are more likely to have private physicians (Mayberry et al., 2000; Walls et al., 2002)
- are less likely to have satisfactory patient-physician relationships (Bowen and Gonzalez, 2008)
- are more likely to use health care settings characterized by longer wait times, overcrowding, and less continuity of care (Derlet et al., 2001)

Why are there differences in the treatment of minority populations?



Multi-level Factors

- Socioeconomic factors may play a larger role than race and ethnicity in the use of preventive services
- Economic access to health care services may or may not explain racial/ethnic differences in health services use
- Cultural differences in care-seeking may influence health care service utilization.
- Other influential factors may include: physician attitudes, patient beliefs about the medical system and about physicians, care-seeking behaviors, language, acculturation, and social isolation of ethnic groups
- Hospitals serving predominantly minority patients are more likely to have nursing shortages and to be inadequately funded
- Black and Latino adults have more *distrust* than Whites of medical research, clinicians, and physician's judgment
- Racism, stigma, and discrimination (or perception of these)

More Resources Are Needed To Increase Diversity in Health Care Workforce

- Minority patients often prefer to be treated by health care professionals of the same ethnic background (IOM, 2004)
- A provider from a patient's own background may have better understanding of culturally appropriate demonstrations of respect for older populations and be more likely to speak the same language
- Providers from minority populations may provide most of the services provided to underserved populations (HRSA, 2006)
- Physicians serving predominantly minority patients are less likely to be board-certified and have less access to clinical resources (Bach et al., 2004)
- The case for diversity also rests on civil rights, public health and educational benefit, and business gains (Grumbach and Mendoza, 2008)



Issue of Trust

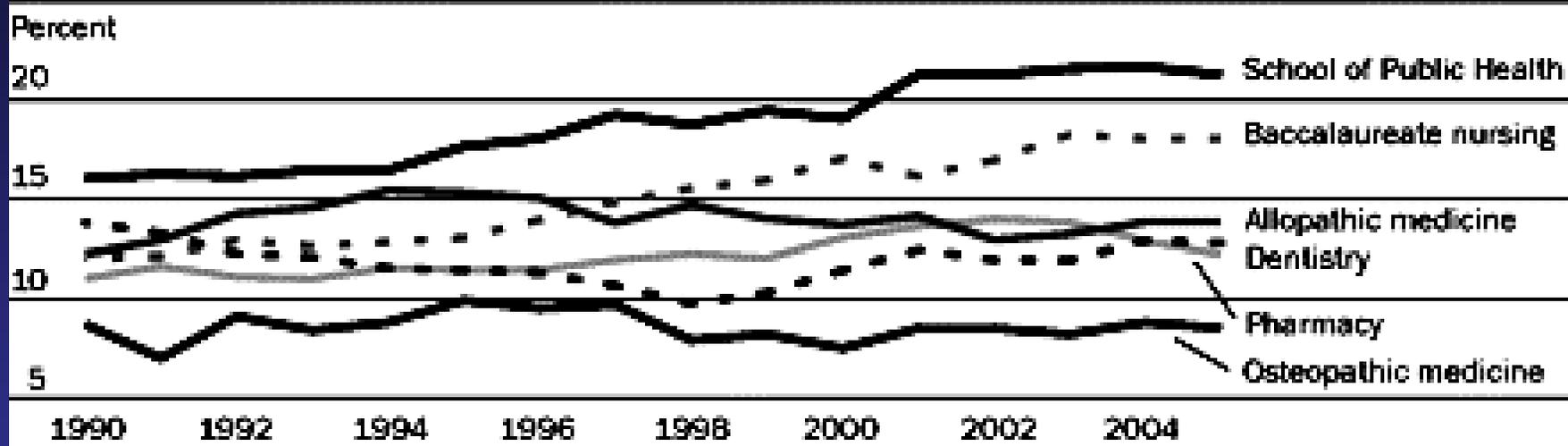
- Trust in one's own personal physician is associated with utilization of preventive health services
- Blacks' relatively high distrust of their physicians likely contribute to health disparities by causing reduced utilization of preventive health services
- LGBT seniors afraid that their health care providers will not treat them with respect and dignity

Why are there differences in the treatment of minority populations?

- Missing Persons: Minorities in the Health Professions
- African Americans, Hispanic Americans, and American Indians represent less than 9 percent of nurses, 6 percent of physicians, and 5 percent of dentists. (Sullivan Commission on Diversity in the Healthcare Workforce, 2004).
- The under-representation of minority health professionals is also reflected in the faculty of health sciences schools.

EXHIBIT 2

Percentage Of Underrepresented Minorities Among U.S. Health Professional Students, 1990-2005



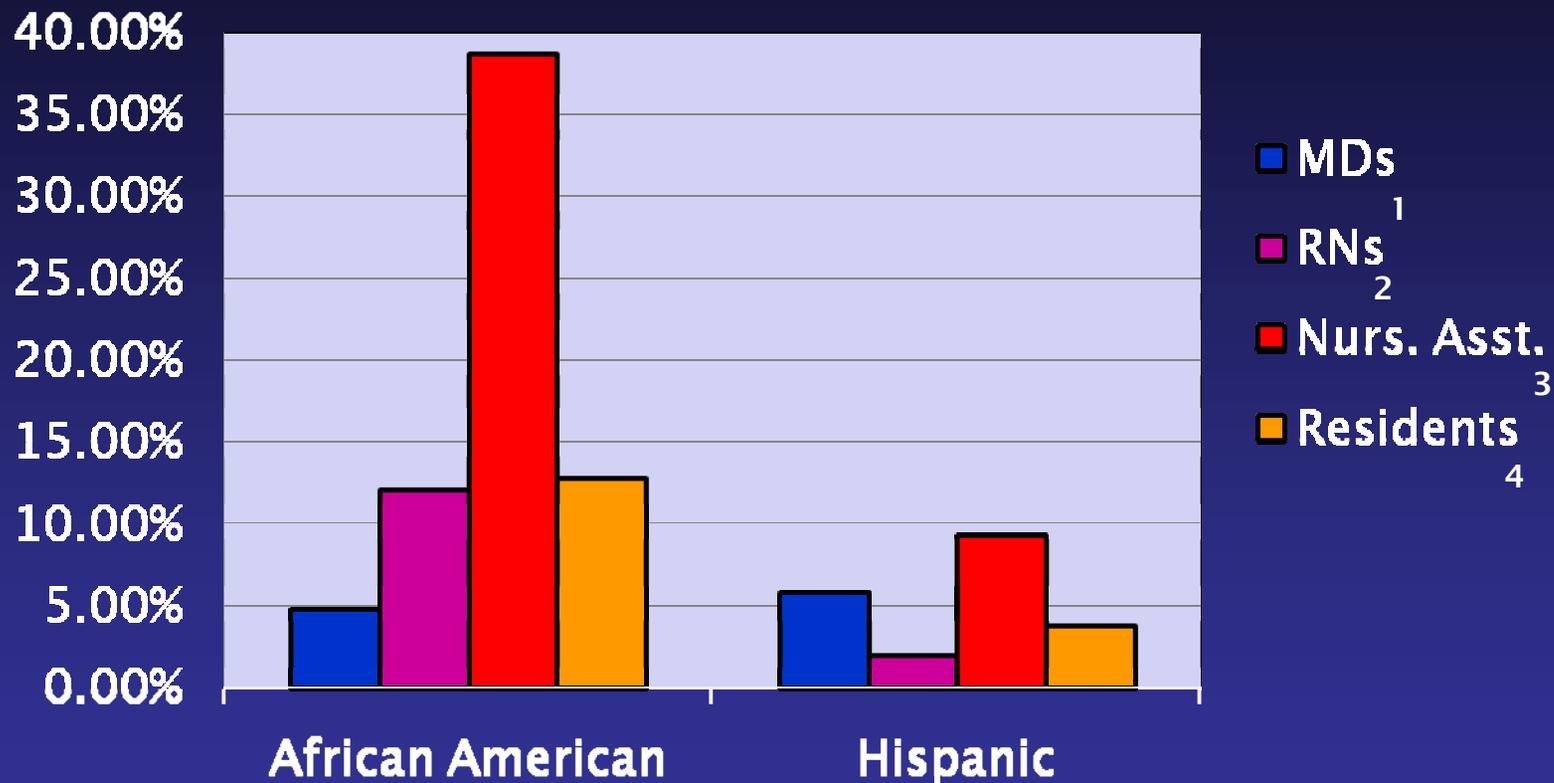
SOURCES: American Association of Colleges of Nursing; American Association of Colleges of Osteopathic Medicine; American Association of Colleges of Pharmacy; Enrollment Survey - Fall 2006 Professional Pharmacy Degree Programs; American Association of Medical Colleges Data Warehouse: Applicant Matriculant File; American Dental Association; and Association of Schools of Public Health.

NOTES: Underrepresented minority is defined as non-Hispanic black, Hispanic/Latino, and American Indian/Alaska Native for these calculations.

Grumbach K, Mendoza R. Disparities in Human Resources: Addressing the Lack of Diversity in the Health Care Professions. *Health Affairs*, 27(2):413-422, 2008



Demographics: Caregivers and Recipients



¹Association of American Medical Colleges, "Complexities of Physician Supply and Demand: Projections through 2025" (2008)

²US Department of Health and Human Services, Health Resources and Services Administration, National Sample Survey of Registered Nurses (2004)

³Centers for Disease Control and Prevention, National Center for Health Statistics, National Nursing Home Survey (2004-2005)

⁴Centers for Disease Control and Prevention, National Center for Health Statistics, National Nursing Home Survey (2004)

Why are there differences in the treatment of minority populations?

Illustrative example: factors associated with failure of depression care in older black primary care patients

- Patient level: personal models of depression, comorbid physical illness, complex medication regimens, cognitive impairment, trust and stigma, health literacy, poverty, lack of social support, lack of health insurance
- Provider level: competing demands, financial disincentives, ageism, lack of cultural sensitivity, racism
- Practice/system level: time constraints, structural disincentives, higher Medicare copays, shortage of Black providers, lack of appropriate information for patients and care givers

Why are there differences in the treatment of minority populations?

- Interviews with 43 depressed, low-income African Americans identified several barriers to receiving depression care.
- The most often reported barriers were public stigma, followed by alcohol or substance abuse, feeling ashamed of being depressed and needing help, and denial of mental illness.

Separate and Unequal: Racial Segregation and Disparities in Quality across U.S. Nursing Homes

- Nursing homes remain relatively segregated, mirroring residential segregation
- Blacks more likely than whites to be located in nursing homes with serious deficiencies, lower staffing ratios, and greater financial vulnerability
- Changing provider behavior won't eliminate disparities—persistent segregation poses a substantial barrier to progress

Smith DB, Feng, Z, et al., Health Affairs, 2007

How can we create the culturally competent workforce that we need?

- Increase the number of minority health care providers, because they are more likely to serve in minority and medically underserved communities
- Address barriers encountered by minority junior faculty in the health sciences
- Use multipronged strategies addressing the educational pipeline, admissions policies, and institutional culture at health professions schools

How can we create the culturally competent workforce that we need?

Knowledge and skills needed in ethnogeriatrics:

- differential health risks
- diverse cultural health beliefs and practice systems
- cohort-specific historic experiences
- culturally appropriate respect
- eliciting elders' explanatory models of their conditions
- working with older adult's families from different cultures
- identifying cultural guides (individuals from the local community who help patients navigate the health care system, keeping cultural preferences in mind)

(Yeo, 2007)

What can be done to ensure appropriate levels of access and quality?

- Enhance geriatric and ethnogeriatric competence in the general healthcare workforce
- Increase recruitment and retention of providers with special expertise in geriatrics and ethnogeriatrics
- Redesign models of care, particularly those that allow greater flexibility of roles and support teams (e.g., IMPACT and PROSPECT)



What can be done to ensure appropriate levels of access and quality?

*Identification of
Diagnosis*

Physician Education

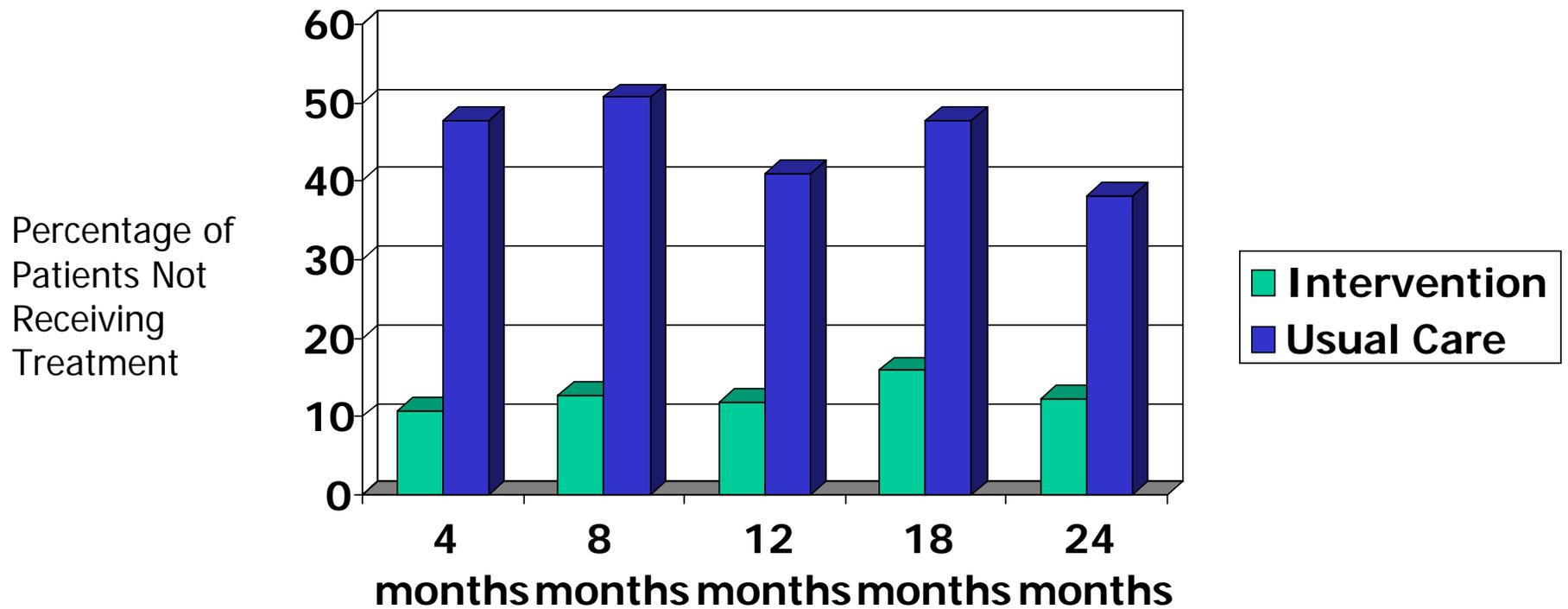
*Patient & Family
Psycho-Education*

***DEPRESSION
SPECIALIST***

&

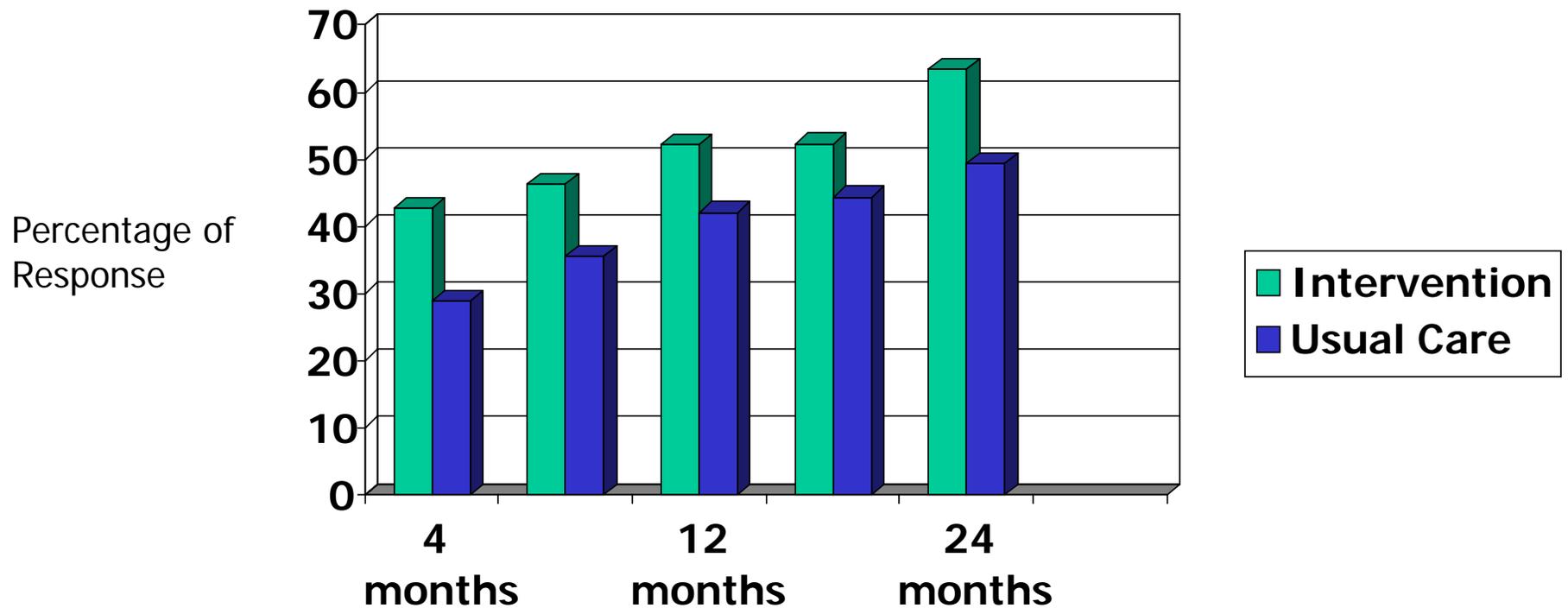
***TREATMENT
ALGORITHM***

Usual Care of Depression is Often No Treatment at All...



Alexopoulos, Reynolds et al., *American Journal of Psychiatry*, (in press)

More Intensive Treatment Leads to Higher Response Rates



Alexopoulos, Reynolds et al., American Journal of Psychiatry, (in press)

For LGBT seniors: Ways to ensure appropriate levels of access and quality

- Written policy on nondiscriminatory practices in clients and services specific to LGBT issues
- Written policy on nondiscriminatory practices in employment regarding sexual orientation and gender identity
- Provide in-training or workshop on issues of sexuality and gender
- Outreach or advertising to local LGBT communities
- Partner with LGBT care providers such as Services and Advocacy for GLBT Elders (SAGE) in NYC, Gay and Lesbian Outreach to Elders (GLOE) in SF
- Health promotion brochures, posters, and language on the in-take forms must be friendly towards and inclusive of LGBT seniors
- Policy makers need to address the needs and concerns of LGBT seniors within the framework of meeting the needs of minority in current policy
- Goal: Ensure safe and sensitive environment that is inclusive of sexual minorities

Summary: Focusing on the Ways in which Minority Group Members Receive Differential Treatment May Reduce Disparities in Health Care Services

- Increasing minority access to primary care and dealing with issues such as overcrowding and longer wait times in emergency rooms may be effective strategies for reducing racial/ethnic disparities in health care (Hasnain-Wynia et al., 2007)
- Need to address both the micro (patient/physician interaction) and macro (clinical resources/access to high quality physicians and hospitals) determinants of health care quality (Smedley, Stith, and Nelson, IOM Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, 2002)

Ability

- Enhance geriatric and ethno-geriatric competence in the healthcare workforce as a whole

*This one patient I have, umm, there's two of 'em . . .
Special lotions – I make sure I have 'em in my purse or . . .
You know, whatever . . . That's gonna help them. These
are black women and their skin has not been taken care
of, so I just brought mine. And, I've been tryin', tryin' to
you know, just do what we do*

African American Nursing Assistant

Opportunity

- Focus on Distribution vs. Proportion of Workforce
- Sorting Exacerbates Rather than Diminishes Segregation

We have this one lady here. She's a racist. She done called me the "N word." She spit on me. She done all kinda stuff to me. I just – they took me off the, well they gave me a choice: you know, just to try another floor, just stay on one floor. So now I'm permanently on one floor.

African American Nursing Assistant

Motivation

We're not always included on "Report" at the beginning of each shift. The nurses feel that they aides [shouldn't be] privy to that information. How you gonna tell me I'm not privy to what's goin' on with that resident when I'm the one that's taken care of [them]? If I'm walkin' into A, B and C, you need to tell me what I'm walkin' into. Yes, I'm supposed to be using universal precautions. But some things aren't just stopped by universal precautions.

African American Nursing

Assistant