HEALTHCARE DISPARITIES

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BELIEVE IN *WE*™ OhioHealth

Objectives:

- Define Healthcare Disparities and factors that influence it.
- Explore the history of disproportionate care in medicine and give examples of current disparities in Healthcare.
- Identify the role implicit and unconscious bias plays as it relates to Healthcare.
- Discover how we as Rehab professional can identify and help to close those disparities for the underserved.

Definitions

Definitions

- **Healthcare Disparities**: The differences between *groups* in health insurance coverage, access to and use of care, and quality of care.[1]
  - *Kaiser Family Foundation*
- **Health Disparities**: Health disparities are *preventable* differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by social, racial, ethnic, economically, geographically, and environmentally disadvantaged population groups, and communities.[2]
  - *Center for Disease Control*

Definitions cont.

- **Social Determinants of Health (SDoH):**[3] are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

- Influenced by forces and systems which include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems.
  - *U.S. Department for Health & Human Services*

Health and Healthcare Disparities

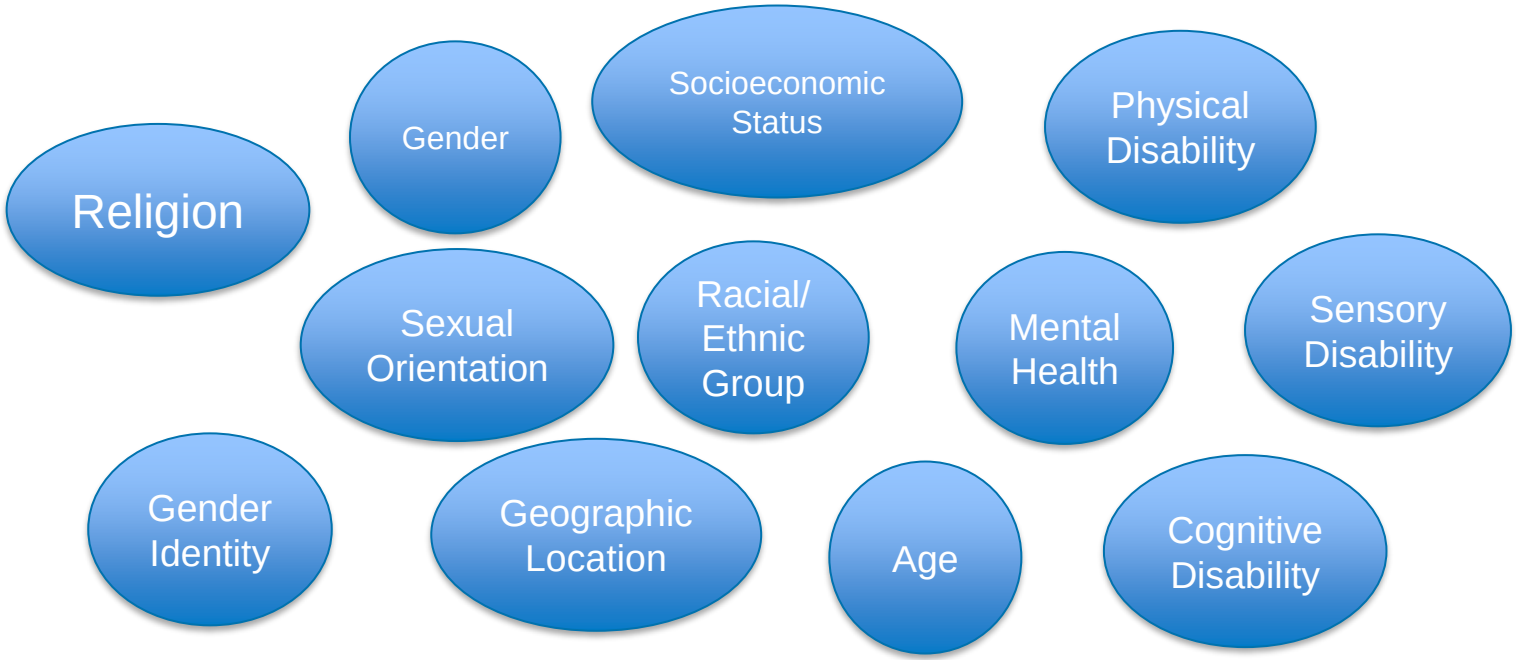
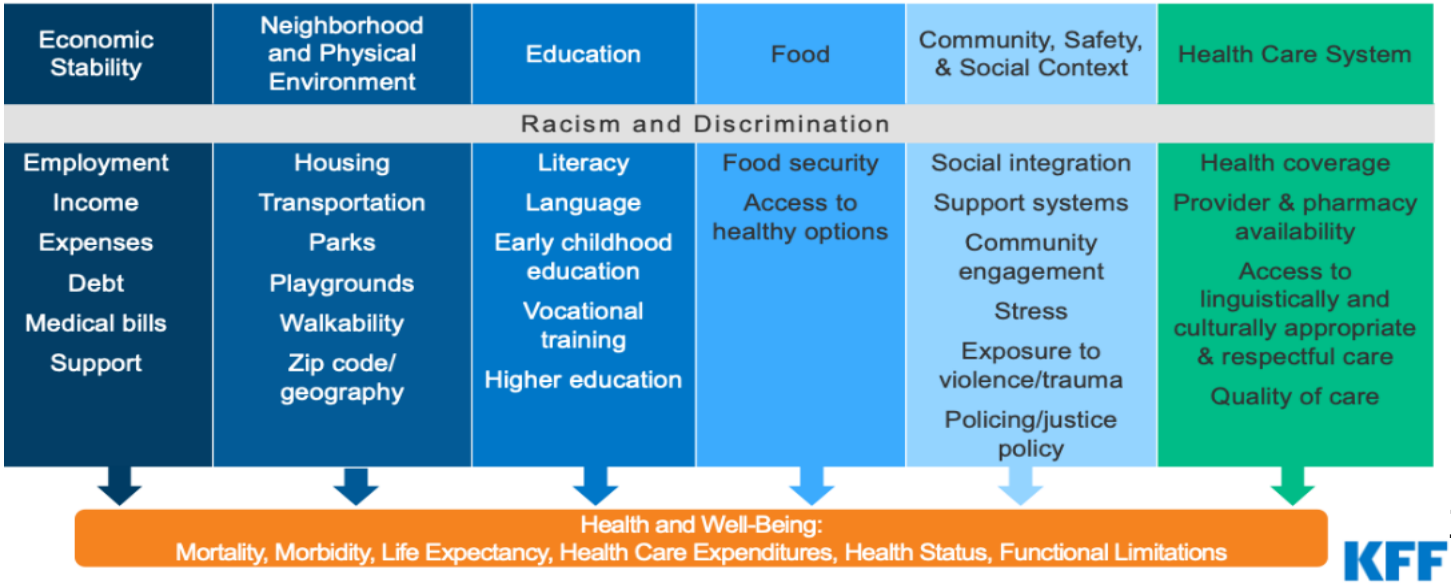


Figure 1

Health Disparities are Driven by Social and Economic Inequities



KFF[1]

Historical Perspective and Origins of Healthcare Disparity

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Historical Origins of bias in Western & U.S Healthcare and Health Systems[4]

- Mesopotamia and Egypt (4000 B.C.)
  - Based on slavery and class
- Greco-Roman(500 B.C.)
  - Plato, Aristotle-"Fathers of modern science and medicine"
  - Hippocratic Tradition
  - Galen of Pergomen
  - Structural systems based on "ranking" race (Blacks and Asians), slavery and class with emphasis on black inferiority clinically, psychologically and intellectually.

Historical Origins of bias in Western & U.S Healthcare and Health Systems[4]

- Middle Ages (500-1130 A.D.)
  - Collapse of Roman Empire
  - Influence of Christian Monks and Arab scholars
  - Increase in Anti-black sentiment (war between white Christians vs. African Moors)
  - Inequities based on race, class, slavery, ethnicity

  The Renaissance Period (14th and 16th centuries)
  - Royal, Aristocratic, Health related enterprise (Medical schools, hospitals)
  - Mediterranean and Atlantic slave trades; Moslem-African vs. Christian European wars
  - Non-whites as inferior; justification for slavery

Historical Origins of bias in Western & U.S Healthcare and Health Systems[4]

- The Age of Science and Enlightenment (1600-1800)
  - Use of skin color (white male superiority); elite and wealthy
  - Slave trade (Africans/Native Americans)
  - Poor living conditions, new diseases, brutality, high mortality rates.
  - Blacks over-utilized for used for surgical, medical demonstrations and dissections.
  - Bias based on race, class, and puritan-oriented morality

Historical Origins of bias in Western & U.S Healthcare and Health Systems[4]

- Colonial, Republican, Jacksonian, and Antebellum Periods (1619-1861)
  - Darwinism
  - Rise in modern biology and anthropology
  - Healthcare equity based on racial hierarchies and biological determinants with blacks, other non-whites and women in the lower echelon.

Historical Origins of bias in Western & U.S Healthcare and Health Systems[4]

- The Civil War
  - Non-military population: based on hierarchical care, race, gender, moral judgments and class
  - Black union soldiers received substandard care, high mortality rates and poor health outcomes.
  - Major shortages of health providers and resources

Historical Origins of bias in Western & U.S Healthcare and Health Systems[4]

Reconstruction, Gilded Age, “Progressive” Era

- Epidemics, homelessness, economic sanitation conditions and abandonment of the medical facilities and personnel willing to serve the Freedman, threatened the entire Black population.
- Emergency Measures placed (economy/capitalism) which led to opening of African-American hospitals, clinics, medical schools.
- Separate but Equal health care
- Inequities based on race and class

Historical Origins of bias in Western & U.S Healthcare and Health Systems[4]

- Early 20th Century
  - Darwinism; IQ testing
  - Imminent extinction of inferior “races” which includes blacks, Jews, Irish, criminals, the poor and the insane.
  - Good breeding and sterilization of the “unfit”
  - Immigrants/Industrial capitalism (Irish, Eastern European Jews, Chinese, Mexican, Japanese).
  - Disparities in health based on race, ethnicity, gender, class, social status, moral code, mentally challenged.

Historical Origins of bias in Western & U.S Healthcare and Health Systems[4]

- The Great Depression & World War II
  - Disruption in the health system
  - More governmental involvement in healthcare
  - Segregation

  Pre-Civil Rights Movement (1957-1965)

  - 1964 Courts outlawed governmental hospital segregation
  - 1965 Passage of Medicare and Medicaid Legislation
  - Increase in desegregation lawsuits against hospitals and medical schools
  - Urgency of scientific advances led to unethical experimentation.

Historical Origins of bias in Western & U.S Healthcare and Health Systems[4]

- Civil Rights Era (1965-1980)
  - Dramatic improvements in health outcomes, status, access and quality of care
  - Affirmative action increased minority representation
  - Opposition to Medicare/Medicaid; institutionalized discrimination against blacks, ethnic minorities and the poor.

Retrenchment Era (1980-1992)

- Unaddressed ethnic, racial, class, gender, cultural segregation; cuts in public funding; increase in numbers of uninsured; inflation; professional inequities; unethical experimentation/treatment.

Historical Origins of bias in Western & U.S Healthcare and Health Systems[4]

- Healthcare Reform & Corporate Takeover (1995-2001)
  - Insurance company/Managed care
  - Selective lock out of black, the poor and the providers that care for them.
  - Disparities in healthcare remain based on race, ethnicity and class.

Healthcare Disparities in the U.S. has a systemic root dating back > 2,000 years and has affected may disadvantaged segments of the population.

Past, Present, Future

- **PBS Series**: **“Origin of Everything”**

“Health Disparities in the Black Community: Past and Present”- 11/13/2020

https://www.pbs.org/video/health-disparities-in-the-black-community-past-present-uzj0ts/

Systemic Cause & Effect[5]

- Mistrust in the medical profession and “Generational” scarring
- Lack of representation in ethical clinical trials
- Access to/offering of medical intervention for similar diagnosis
- Compliance with medical intervention and treatment
- Lack of representation in the medical profession

Examples of Current research and its Healthcare Implications

“Diversity and Inclusion in Quality Patient Care: Your Story/Our Story-A Case-Based Compendium”[6]

People with Disabilities or those who require accommodations to access health care, medical information, or medical education:

- Disproportionate or reduced appointment availability
- Lack of accessible transportation
- Lack of timely transportation
- Increased cost and insurance barriers
- Inadequate/poor physician-patient communication

  -leads to healthcare misconceptions
- Poor health literacy
- Negative attitudes, lace of respect and discrimination

Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them

Latoya Hill , Samantha Artiga , and Usha Ranji

Published: Nov 01, 2022

Racial Equity and Health Policy

Original Research

ajog.org

GYNECOLOGY

Black and Hispanic women are less likely than white women to receive guideline-concordant endometrial cancer treatment

Mara Kaspers; Elyse Llamocca, MPH; Allison Quick, MD; Jhalak Dholakia, MD; Ritu Salani, MD; Ashley S. Felix, PhD

American Journal of Obstetrics & Gynecology SEPTEMBER 2020

ORIGINAL RESEARCH

Disparities in Receiving Guideline-Concordant Treatment for Lung Cancer in the United States

Erik F. Blom[1,2*], Kevin ten Haaf[1], Douglas A. Arenberg[2], and Harry J. de Koning[1]

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ORCID ID: 0000-0002-2016-5668 (E.F.B.).

AnnalsATS Volume 17 Number 2 | February 2020

JAMA Network Open

Original Investigation | Public Health

Association of Rurality, Race and Ethnicity, and Socioeconomic Status With the Surgical Management of Colon Cancer and Postoperative Outcomes Among Medicare Beneficiaries

Niveditta Ramkumar, PhD, MPH; Carrie H. Colla, PhD; Qianfei Wang, MS; A. James O'Malley, PhD; Sandra L. Wong, MD, MS; Gabriel A. Brooks, MD, MPH

JAMA Network Open. 2022;5(8):e2229247. doi:10.1001/jamanetworkopen.2022.29247

August 30, 2022

JAMA Internal Medicine | Original Investigation

Racial and Ethnic Discrepancy in Pulse Oximetry and Delayed Identification of Treatment Eligibility Among Patients With COVID-19

Ashraf Fawzy, MD, MPH; Tianshi David Wu, MD, MHS; Kunbo Wang, MS; Matthew L. Robinson, MD; Jad Farha, MD; Amanda Bradke, MD, MA; Sherita H. Golden, MD, MHS; Yanxun Xu, PhD; Brian T. Garibaldi, MD, MEHP

JAMA Health Forum. 2021;2(12):e214223. doi:10.1001/jamahealthforum.2021.4223 December 23, 2021

LGBT+ People's Health and Experiences Accessing Care

Lindsey Dawson , Brittni Frederiksen , Michelle Long , Usha Ranji , and Jennifer Kates

Published: Jul 22, 2021

Racial and Ethnic Disparities in the Utilization of Thrombectomy for Acute Stroke

Analysis of Data From 2016 to 2018

Lorenzo Rinaldo, MD, PhD; Alejandro A. Rabinstein, MD; Harry Cloft, MD, PhD; John M. Knudsen, MD; Leonardo Rangel Castilla, MD; Waleed Brinjikji, MD

Received December 17, 2018; final revision received March 15, 2019; accepted May 2, 2019.
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Stroke **is available at https://www.ahajournals.org/journal/str** **DOI: 10.1161/STROKEAHA.118.024651**

NARROWING THE GAP IN HEALTHCARE DISPARITIES AND OUR ROLE AS REHAB PROFESSIONALS

“Healthy People 2030”[3]

Data-driven national objectives in five key areas of SDOH: ***healthcare access and quality***, education access and quality, social and community context, economic stability, and neighborhood and built environment. Some examples of SDOH included in Healthy People 2030 are safe housing, transportation, and neighborhoods; polluted air and water; and access to nutritious foods and physical health opportunities.

- **Our Pledge[7]**
- *We honor the dignity and worth of each person.*
- We believe our first responsibility is to the patients we serve. We *respect the physical, emotional and spiritual needs of our patients* and find that compassion is essential to fostering healing and wholeness.
- We believe our patients and their families deserve *the best possible healthcare experience*. We are committed to the pursuit of excellence in all that we do. Teaching and learning are fundamental in our efforts.
- We believe we are *accountable to our communities for our stewardship*. We have a special concern for the poor, and *are committed to making quality healthcare available to all*. Our decisions will serve our communities in the present and preserve our mission into the future.
- We believe our actions and decisions must reflect a faithful balance of our core values. We will act with absolute integrity and expect the same of those who work with us.
- We believe our people are the source of our success. *Our organization must reflect the rich diversity of our communities. We will respect, embrace and derive strength from our differences*. We are committed to providing a work environment that enables our employees to fulfill their professional, family and community responsibilities.
- We believe that *spiritual diversity* within our organization must be respected and celebrated. Our relationship with the United Methodist Church grounds us in a strong moral and ethical foundation. Throughout the organization, we exist to serve others.
- ***Our every action must advance our mission: To improve the health of those we serve.***

OhioHealth Vision Statement[7]

APTA
American Physical Therapy Association

- [8]**Mission Statement:** “Building a community that advances the profession of physical therapy to improve the health of society.”
- **Vision Statement:** “Transforming society by optimizing movement to improve the human experience.”

Guiding principles to achieve the vision:

Identity	Innovation
Quality	Consumer-centricity
Collaboration	Access/Equity
Value	Advocacy

American Speech-Language-Hearing Association

[9]VISION Statement: Making effective communication, a human right, accessible and achievable for all.

MISSION Statement: Empowering and supporting audiologists, speech-language pathologists, and speech, language, and hearing scientists through advancing science, setting standards, fostering excellence in professional practice, and advocating for members and those they serve.

CORE VALUES:

- Excellence
- Diversity
- Research-Based
- Responsive
- Integrity
- Commitment
- Member-centric

American Occupational Therapy Association

Vision 2025[10]

As an inclusive profession, occupational therapy maximizes heath, well-being, and quality of life for all people, populations, and communities through effective solutions that facilitate participation in everyday living.

NATIONAL CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES STANDARDS (CLAS)[11]

- First published in 2000 by The Office of Minority Health of the U.S. Department of Health & Human Services
- 2013 Updated version called Enhanced National CLAS Standards
- National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by providing a blueprint for individuals and health and health care organizations to implement culturally and linguistically appropriate services.

Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

OMH U.S. Department of Health and Human Services Office of Minority Health

Think Cultural Health
https://www.thinkculturalhealth.hhs.gov/
contact@thinkculturalhealth.hhs.gov

Impact of Rehab Services

- SEEKING
- BUILDING
- LAUNCHING
- ENGAGING

SEEKING

Inward and Outward

- Identification of a Problem
  - Implicit/Unconscious Bias
  - Implicit Association Test (IAT)
  - Perspective-taking: cognitive component of empathy[12]
  - Emotional regulation skills: positive emotions during patient interactions
  - Partnership-building skills: create partnerships with patient; “same team” working towards a common goal.
  - Diversity, Equity and Inclusion Programs

Implicit Association Test (IAT)[13]

- Computer based test developed by researchers at Harvard University, the University of Washington and the University of Virginia.
- The Implicit Association Test (IAT) measures the strength of associations between concepts and evaluations or stereotypes to reveal an individual's hidden or subconscious biases.
- **https://implicit.harvard.edu/implicit/**

Types of Implicit Association Tests[13]

- **Native American** (‘Native-White American last name recognition)
- **Gender-Career** (Link between Family/females; Career/males)
- **Gender-Science** (Link between Liberal Arts/females; science/males)
- **Weapons** (‘Weapons-Harmless Objects’-White and Black faces and images of weapons/harmless objects)
- **Presidents** (Presidential popularity)
- **Race** (‘Black-White’ preference)
- **Skin-tone** (‘Light Skin-Dark Skin preference)
- **Sexuality** (‘Gay-Straight preferences
- **Arab-Muslim** (‘Arab Muslim-Other People’-distinguish names Arab-Muslim names vs. other nationalities/religions)
- **Weight** (‘Fat-Thin’ preferences)
- **Asian American** (‘Asian-European American images, American vs. Foreign places)
- **Age** (‘Young-Old’ preferences)
- **Religion** (‘Religion’-religious terms
- **Transgender** (‘Transgender People-Cisgender People’-distinguish celebrities
- **Disability** (‘Physically Disabled-Physically Abled’-recognizing figures representing this population)

From the Society for Vascular Surgery

SVS | Society for Vascular Surgery

Persistent racial discrimination among vascular surgery trainees threatens wellness

Eric B. Pillado, MD,[a] Ruojia Debbie Li, MD, MS,[a] Joshua S. Eng, PhD,[a] Matthew C. Chia, MD, MS,[a] Allan Conway, MD,[b] Clara Gomez-Sanchez, MD,[c] Palma Shaw, MD,[d] Malachi G. Sheahan III, MD,[e] Karl Y. Bilimoria, MD, MS,[a] Yue-Yung Hu, MD, MPH,[a] *and* Dawn M. Coleman, MD,[f] *Chicago, IL; New York and Syracuse, NY; San Francisco, CA; New Orleans, LA; and Ann Arbor, MI*

Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites

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www.pnas.org/cgi/doi/10.1073/pnas.1516047113

Racial Segregation and Inequality of Care in Neonatal Intensive Care Units Is Unacceptable

Elizabeth A. Howell, MD, MPP; Paul L. Hebert, PhD; Jennifer Zeitlin, DSc, MA

JAMA Pediatrics May 2019 Volume 173, Number 5 jamapediatrics.com

“Health-care providers recognize that removing bias and understanding the cultural patterns of patients not only creates greater equity but also creates greater patient health outcomes. Educational institutions know that a diverse student body creates a better scholastic experience for their learners and that the quality of teaching improves when teachers demonstrate more inclusivity and less bias.”[14]

Implicit Racial Bias in Medical School Admissions

Quinn Capers IV, MD, Daniel Clinchot, MD, Leon McDougle, MD,
and Anthony G. Greenwald, PhD

Abstract

Problem
Implicit white race preference has been associated with discrimination in the education, criminal justice, and health care systems and could impede the entry of African Americans into the medical profession, where they and other minorities remain underrepresented. Little is known about implicit racial bias in medical school admissions committees.

Approach
To measure implicit racial bias, all 140 members of the Ohio State University College of Medicine (OSUCOM) admissions committee took the black–white implicit association test (IAT) prior to the 2012–2013 cycle. Results were collated by gender and student versus faculty status. To record their impressions of the impact of the IAT on the admissions process, members took a survey at the end of the cycle, which 100 (71%) completed.

Outcomes
All groups (men, women, students, faculty) displayed significant levels of implicit white preference; men ($d = 0.697$) and faculty ($d = 0.820$) had the largest bias measures ($P < .001$). Most survey respondents (67%) thought the IAT might be helpful in reducing bias, 48% were conscious of their individual results when interviewing candidates in the next cycle, and 21% reported knowledge of their IAT results impacted their admissions decisions in the subsequent cycle. The class that matriculated following the IAT exercise was the most diverse in OSUCOM's history at that time.

Next Steps
Future directions include preceding and following the IAT with more robust reflection and education on unconscious bias. The authors join others in calling for an examination of bias at all levels of academic medicine.

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BUILDING

- Restore, Rebuild, Repair
  - Which aspect of disparities in Healthcare will you target?
    - Foundational targets
    - Access to care based on a particular diagnosis/condition
    - Misrepresentation of certain group(s) in medicine

Building cont.

- Building Highly Effective Relationships[15]
  - People who feel respected, included and valued are able to contribute their best
  - Cultivation Connections
    - Market your profession and its mission and values
    - Utilize the intellectual and interpersonal approach of empathy and curiosity
    - Get to know the client (inward and outward) which will help to dispel biases.

LAUNCHING

- Market your target audience and increase awareness in your communities and spheres of influence.
- Collaboration with other health care providers, disciplines, agencies and organizations that serve your targeted audience.
- Provide Educational and Training Opportunities

Engaging

- Build Trust
- Develop Programs that demonstrates commitment and growth.
- Evidence-Based Practice
- Utilize Creative Treatment and Educational opportunities and Resources
- Outreach: “Coming to” vs. “Going out”

Build upon a Foundation[16]

- Early assessment using formal diagnostic tools to identify specific speech and language delays and disorders.
- Assure that these efforts are sensitive to needs of cultural and language minorities
- Improve access to services for the most vulnerable population (Minorities, hearing impaired)
- Involvement in literacy programs for children and adults

EDITORIAL

Explaining and addressing racial disparities in stroke care and outcomes

A puzzle to solve now

Roland Faigle, MD, PhD, and Lisa A. Cooper, MD, MPH

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Interventions Targeting Racial/Ethnic Disparities in Stroke Prevention and Treatment

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[6]Department of Population Health and Department of Medicine, New York University Grossman School of Medicine, New York, NY

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