ALL THINGS BEING EQUAL: DISPARITIES IN PEDIATRIC AND WOMEN’S HEALTH

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OBJECTIVES

• Describe the role of health inequities in health care
• Describe the rationale for using Medicaid as a vehicle to address disparities
• Identify ethical dilemmas and challenges inherent to using Medicaid to address disparities
HEALTH DISPARITIES AND HEALTH EQUITY
Racial or ethnic differences in the quality of health care that are not due to access related-factors, clinical needs, preferences, and appropriateness of interventions

CONCEPTUALIZING A HEALTH DISPARITY

- Inequality – **Difference** in condition or rank
- Inequity – **Difference** that is unfair and unjust, unnecessary and avoidable
QUALITY OF HEALTH CARE

WHO IS VULNERABLE?

- Race/ethnicity
- Socioeconomic status
- Rural
- History of experiencing racism, bias, or discrimination
- New subpopulations – immigrants, sexual orientation, stigmatizing conditions
MULTI-LEVEL FACTORS

- Patient
- Provider
- Clinical encounter
- Health care system
LOW-QUALITY HOSPITALS

Understand disparities in the use of hospitals for major surgery

• Determine racial differences in the proportion of patients having surgery in low- and high quality hospitals

• Determine whether geographic proximity to low- and high quality hospitals explains differences

LOW-QUALITY HOSPITALS

- Data source – Medicare files
- Subjects – Individuals 65 years and older undergoing coronary artery bypass grafting, abdominal aortic aneurysm repair, or resection for lung cancer
- Hospital quality
- Geographic proximity
- Analysis – Logistic regression

LOW-QUALITY HOSPITALS

- Blacks more likely to have surgery at low-quality hospitals
- Blacks less likely to have surgery at high-quality hospitals
- Blacks lived closer to high-quality hospitals

LOW-QUALITY HOSPITALS

- Referral patterns of primary care providers
- Metrics for quality not known to patients
- Bad experiences at “high quality” hospitals for patient, family, or friends
- Good experiences at “low quality” hospitals for patient, family, or friends
- “Low quality” hospitals have services and personnel to support patient
PHYSICIAN BIAS

• Goal – Determine physician preferences and stereotypes affecting clinical decision making for white and black patients

• Subjects – Emergency residents in 4 academic medical centers

• Web based instrument randomly assigned participants to see a picture of a white or black patient while reading a clinical vignette

• 50 year old male presenting with chest pain in ER

PHYSICIAN BIAS

- Participants rated likelihood of coronary artery disease, whether they would give thrombolysis, and strength of recommendations
- Explicit bias assessed through questions about racial preferences
- Implicit bias assessed through association of white and black race with good and bad terms
- Analysis – Linear regression

White People
or
Good

Black People
or
Bad
PHYSICIAN BIAS

- Physicians reported no explicit bias
- Physicians showed implicit favoring towards whites
- Physicians showed implicit stereotypes of blacks
- As implicit bias favoring whites increased so did likelihood of treat whites and not blacks with thrombolysis

BEHAVIORAL HEALTH DISPARITIES IN PRIMARY CARE

• Determine demographic and visit characteristics of families referred for behavioral health consultation
• Identify how services provided differ according to language
• Determine which cultural factors are noted in progress notes
• Identify what factors are associated with referral to outpatient behavioral health.

BEHAVIORAL HEALTH DISPARITIES IN PRIMARY CARE

- Setting – Residency training pediatric primary care clinic
- Data Source – Electronic medical record review
- Subjects – Publicly insured children receiving behavioral health consultation
- Analysis – Conventional content analysis and logistic regression

BEHAVIORAL HEALTH DISPARITIES IN PRIMARY CARE

• English-speaking families more likely to receive behavioral health consultations than Spanish or Other language families (birth to 6 years of age)

• Health professionals discussed fewer topics with Other language families compared to English and Spanish speaking families

MATERNAL HEALTH

• Continued increase in maternal mortality ratio since 2007
• Increase in maternal mortality ratio most dramatic in Black women
• Black women die at a rate 3-4 times of white counterparts (unchanged for six decades)
• American Indian and Alaskan Native women have twice as many pregnancy-related deaths per 100,000 live births relative to white women

SICKLE CELL DISEASE

• Inherited red blood cell disorder in which individuals have abnormal hemoglobin
• Manifestations include pain, severe infections, stroke
• Median life expectancy in mid 40s
• Approximately 100,000 individuals in US
• Largely affects individuals with African heritage
SICKLE CELL DISEASE: A MICROCOSM OF DISPARITIES

• Advent of treatments and diagnostic tools
  - hydroxyurea, screening for stroke risk
• Increasing life expectancy

But also…

• Persistently high resource utilization
• High risk of mortality at early adulthood
• Largely underserved population
• Poor funding and organizing relative to other conditions
HEALTHY SKEPTICISM ON HEALTH DISPARITIES

• Incomplete accounting for all contributing variables
• Socioeconomic status as the true driver of inequities
• Statistical significance versus Clinical Importance
• Unclear where to study disparities
• Lack of identifiable solutions
  – If you can’t change demographics, what can you do?
HEALTH EQUITY

- The opportunity for everyone to attain his or her full health potential
- No one is disadvantaged from achieving this potential because of his or her social position or other socially determined circumstance
- Distinct from health equality
HEALTH EQUITY IN PICTURES
SOCIAL DETERMINANTS OF HEALTH

- Life-enhancing resources, such as food supply, housing, economic and social relationships, transportation, education and health care, whose distribution across populations effectively determines length and quality of life.
RATIONALE FOR ADDRESSING SOCIAL DETERMINANTS OF HEALTH

• Health care only accounts for 10-20% of health outcomes

• U.S. spends much less on social services relative to health care but has worse health outcomes relative to other countries that spend more on social services

• Treating the whole patient
The Determinants of Health

- Social and Economic Factors, 40%
- Health Behaviors, 30%
- Clinical Care, 10%
- Physical Environment, 10%
- Genes and Biology, 10%
HEALTH AND SOCIAL CARE SPENDING AS A PERCENTAGE OF GDP

[Chart showing health and social care spending as a percentage of GDP for various countries, with data points for countries like FR, SWE, SWIZ, GER, NETH, US, NOR, UK, NZ, CAN, and AUS.]

September 13, 2018
https://www.brookings.edu/blog/up-front/2017/02/15/re-balancing-medical-and-social-spending-to-promote-health-increasing-state-flexibility-to-improve-health-through-housing/
STRATEGIES TO ADDRESS SOCIAL DETERMINANTS OF HEALTH (SDH)

- Clinical – cultural competency, quality improvement
- Research – root causes, intervention development
- Education – Incorporate into core competencies for medical school, residency training
- Community Resources – continue funding
THE POTENTIAL OF INSURERS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH
THE UNIQUE POSITION OF MEDICAID

• Medicaid and the Children’s Health Insurance Program cover nearly 45% of children under 6 years of age

• Racial/ethnic composition of children in Medicaid: 35% White, 25% Black, 36% Hispanic

www.CMS.gov
Figure 6
Medicaid Pays for Nearly Half of all Births in the U.S.

U.S. Average = 48%

NOTES: **Delaware did not have financial figures for 2010.**
Figure 1

Medicaid Covers 25 Million Adult Women in the United States

Among 69.3 million beneficiaries

- Children under age 18: 44%
- Men 19 and older: 21%
- Women 19 and older: 36%
- 19-49: 67%
- 50-64 years: 17%
- 65 and older: 16%

Age distribution among 25.0 million women 19 and older

NOTES: Enrollment estimates based on full year of data for only 28 states and part-year of data for an additional 17 states. Total enrollment currently is likely higher than 69.3 million people as the data shown does not include some states and does not capture the full effect of the ACA expansion. 2014 data unavailable for AK, CO, Fl, KS, NC and RI and for all four quarters of AL, DC, DE, IL, KY, MO, ME, MT, ND, NE, NH, NM, NV, SC, TX, VA, & WI; excluded from US totals. Due to data security measures, the values of cells with fewer than 50 enrollees are not reported nor included in the state or national totals.

Sources of Children’s Coverage in Texas

- Medicaid and CHIP: 41%
- Employer-Sponsored Insurance: 38%
- Purchased directly from an Insurer, including Marketplace plans: 9%
- Other including Medicare, Tricare, VA: 6%
- Uninsured: 5%

Georgetown University Center for Children and Families and the American Academy of Pediatrics.
http://ccf.georgetown.edu/2017/04/19/snapshot-source-2/
RATIONALE FOR MEDICAID TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

- Single largest health insurer in U.S. with over 74 million beneficiaries
- Infrastructure to serve as base to design an integrated and social service system
- State-federal partnership allows program tailoring for individual states and links between state and federal agencies
- Medicaid already serves many of the individuals who could benefit from non-health services (e.g., housing supports, temporary assistance)
- Focus on SDH can reduce unnecessary use of expensive medical care

National Quality Forum. A Framework for Medicaid Programs to Address Social Determinants of Health: Food Insecurity and Housing Instability
MEDICAID OPTIONS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

- Delivery System Reform Incentive Program (DSRIP)
- Risk Adjustment for SDH in payment models
- Alternative Payment Models to Pay Providers
- Incentivization of Health Plans to Invest
- Nontraditional Services

DELIVERY SYSTEM REFORM INCENTIVE PROGRAM (DSRIP)

- Requires states to reduce hospitalizations, improve outcomes, and move Medicaid providers to value-based contracts
- Under Section 1115 of the Social Security Act, Medicaid programs can transform state health care systems through “infrastructure development, system redesign, clinical outcomes improvement, and population-focused improvements”
- Monies can be used for services such as job training, support groups, rental subsidy assistance, etc.
RISK ADJUSTMENT FOR SOCIAL DETERMINANTS

- Typically relative risk adjustment is solely diagnosis based
- No adjustment for income, education, or housing status
- Without adjusting for SDH, states may financially penalize managed care organizations for caring for people with significant social challenges
- By adjusting payments for SDH, states can mitigate against burnout and dissatisfaction among providers caring for the underserved
• Texas — 78%
REVISION OF MEDICAID MANAGED CARE REGULATIONS

- 2016 – Centers for Medicare and Medicaid Services updated Medicaid managed care regulations
- Modernization of operations, accountability, and oversight
- Promotion of practices that look beyond clinical care to address social and structural factors impacting health
ALTERNATIVE PAYMENT MODEL (APM)

• States can implement incentive-based payment systems for managed care entities.
• States can require managed care plans to implement APMs for their providers.
• Models may include investments in service delivery that connect health with non-medical factors such as screening for domestic abuse, environmental hazards in the home, food insecurity, and housing instability.
States can create payment incentives for health plans, including potentially establishing performance metrics related to social and structural determinants of health.

States may withhold part of a health plan’s capitation rate unless it exceeds a state-set goal for a specified outcome (e.g., reducing maternal mortality, lead screening for children).
NONTRADITIONAL SERVICES

In-lieu of services
- Substitutes for a similar service covered under the contract
- E.g., home visit in place of prenatal clinic visit

Value-added services
- Extras unrelated to the contracted services
- Examples include nutrition classes, peer support services, home delivered meals after hospital discharge
CHALLENGES OF USING MEDICAID TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

- Data
- Screening
- Return on Investment
- Unintended Consequences
PRIMARY ROLES OF DATA

• Identify most vulnerable populations
• Aids in design of new care models and service delivery
• Informs development of payment models and risk adjustment
DATA LIMITATIONS

• No standardized or validated measures
• Variation in how data are collected, used, and reported
• Security and privacy concerns
• IT development costs
• Data sharing agreements across sectors
• Overlapping state and federal laws
SCREENING FOR SOCIAL DETERMINANTS

• Focused vs. expanded screening
• Tool selection
• Incorporation into busy practice
• Collection and updating of community resources
• Ethics of screening for factors for which there are no known available resources
• Potential to overburden community agencies
RETURN ON INVESTMENT

• Investment-benefit relationship mismatched in time, especially in child health

• Investments made by health plans may lead to benefits and savings in other sectors
UNINTENDED CONSEQUENCES

• Initiatives become victims of their own success and eventually create longer-term disincentives to engage in value-based payment programs

• Adjusting performance measurement by SDH could create inappropriate incentives by artificially boosting performance scores of providers treating vulnerable individuals (i.e., acceptable to provide poor care and forego improvement)
CONCLUSIONS

• Health inequities persist despite advances in clinical care, research, and policy

• Payors, specifically Medicaid, have the potential to reduce inequities...and create long-term problems

• Evidence base for Medicaid investment to address SDH evolving

• Pediatricians play a major role in these investments
QUESTIONS AND COMMENTS