Reaching for excellence

Community Vision and Voices for Western New York Health Care

December 15, 2008

Achieving Equity in Health Care Quality Throughout Western New York: Building Community Leadership and Care System Accountability

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane." *– Martin Luther King, Jr.*

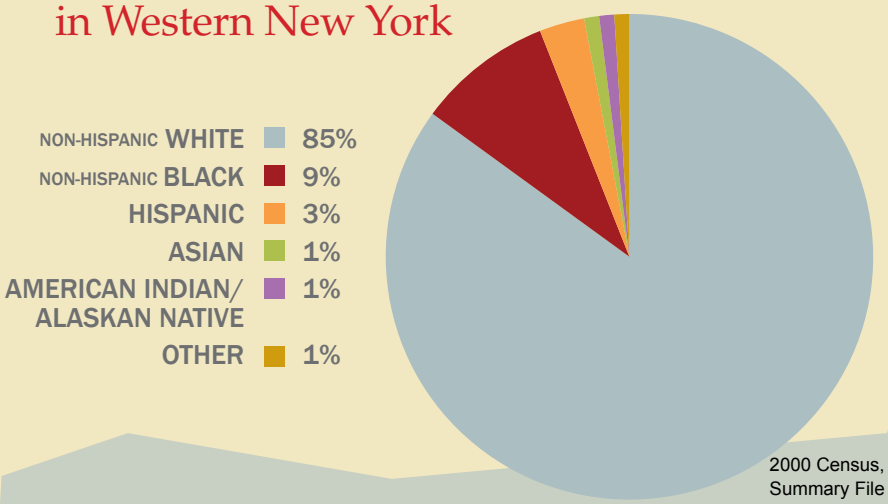
"Overall, the evidence demonstrates that, when appropriately designed and managed, health systems can address health equity. They do this when they specifically address the circumstances of socially disadvantaged and marginalized populations, including women, the poor and other groups excluded through stigma and discrimination."

– World Health Organization Commission on Social Determinants of Health, "Challenging Inequity through Health Systems"

The American health care system is the most expensive in the world, yet it falls near the bottom in meeting one of the most fundamental principles of health care – providing equitable, accessible and quality care to all. According to a report by the Commonwealth Fund, the United States holds last place among countries in preventing deaths through the use of timely and effective medical care, a pattern that disproportionately affects racial and ethnic minority populations. Since the release of the Institute of Medicine report, *Unequal Treatment*, the problem of racial and ethnic health care disparities and related poor health outcomes has been a topic of broad concern.

Figure 1

Percent of Population by Race/Ethnicity in Western New York

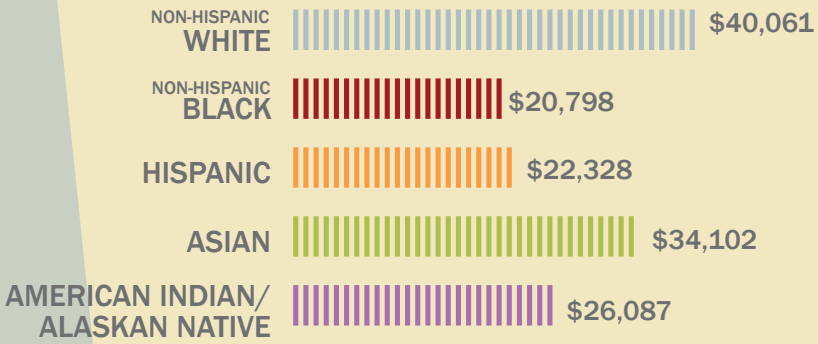


2000 Census, Summary File SF1

In 2000, about 33 percent of the U.S. population identified themselves as members of racial or ethnic minority groups, including blacks, Hispanics, American Indians/Alaskan Natives and Asian/Pacific Islanders. By 2050, these groups are projected to account for almost half the U.S. population, highlighting the immediacy of the health disparities issue as related social and economic costs become increasingly evident across the region and nation. In Western New York, racial and ethnic minorities comprise about 15 percent of the population **(Figure 1)**.

Figure 2

Median Household Income by Race/ Ethnicity in Western New York



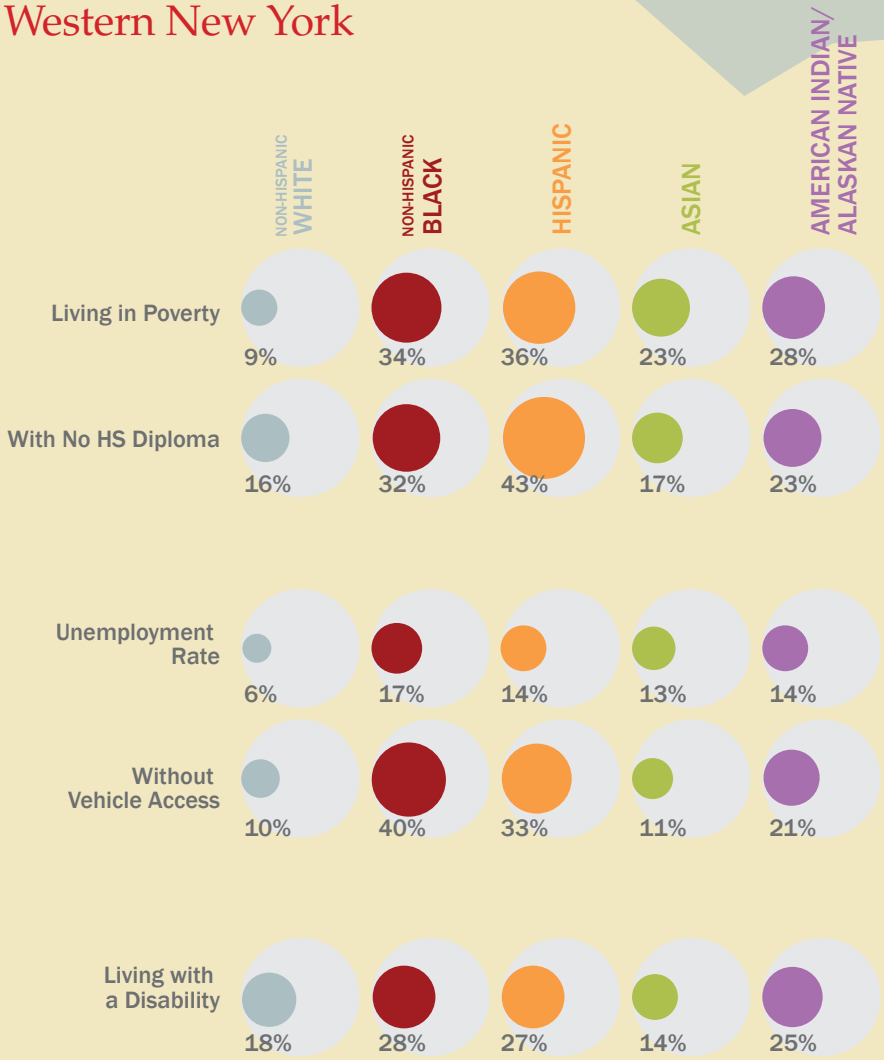
2000 Census, Summary File SF3

Recently, the Disparities Solution Center at Massachusetts General Hospital reported that minorities more frequently miss opportunities for health promotion and disease prevention, experience higher mortality for conditions amenable to surgery, more frequently visit emergency rooms, see higher rates of medical errors and stay in hospitals longer for the same clinical condition. Western New York is consistent with the national trend; Its minority populations, behind in nearly every socioeconomic category, are disproportionately uninsured, receive less preventive care, experience more preventable conditions and have a higher prevalence of chronic health conditions such as obesity and diabetes.

Socioeconomic Inequities. Health care disparities cut across many dimensions, including race, ethnicity, socioeconomic status and geography. Because these factors are so very closely correlated nationally as well as regionally, it can be difficult to isolate their roots. Nonetheless, as data reported in *Health Affairs* indicate, fewer community resources, limited access to care and high-risk behaviors are associated with low socioeconomic status. In the eight-county region of Western New York, racial and ethnic minorities commonly face this structural disadvantage, experiencing disproportionately lower income **(Figure 2)**, more poverty, lower education levels, higher unemployment and more limited access to vehicles **(Figure 3)**.

Figure 3

Socioeconomic Conditions by Race/Ethnicity in Western New York



2000 Census, Summary File SF3

Median household income for blacks is about half that of whites, and slightly more than half for Hispanics and American Indians/Alaskan Natives (**Figure 2**). Blacks and Hispanics are about three times as likely to live in poverty compared with whites (**Figure 3**). Such economic disadvantages exacerbate the issue of health care affordability for these populations.

Low education is further correlated with poverty and unemployment. Education levels are markedly lower for minorities, as 43 percent of Hispanics and 32 percent of blacks are without a high school degree, compared with 16 percent of whites.

Unemployment rates are more than twice as high among Hispanics, blacks, and American Indians/Alaskan Natives relative to whites.

Blacks and Hispanics are three times as likely to lack access to a vehicle, severely limiting access to services and providers.

Compared with whites, significantly higher proportions of blacks, Hispanics, and American Indians/Alaskan Natives live with a disability, presenting these populations with higher health care costs and greater need for affordable, reliable health insurance.

Cultural differences among the patients, providers and even the system itself also impact health care disparities. For instance, language barriers and literacy deficiencies can interfere with communication between patients and providers and further complicate the process of navigating the health system. In Western New York, in the City of Buffalo, 21 percent of households are "linguistically isolated," or have difficulty speaking English.[1] Different historical experiences, cultural views and even mistrust of the health system can affect how care is sought or treatment is provided.

[1] According to the 2000 U.S. Census, "linguistically isolated" is a household in which all persons age 14 or older either speak only a non-English language or speak English less than "very well." All the members of a linguistically isolated household are tabulated as linguistically isolated, including members under 14 years who may speak only English.

Disparities in Health Care and Health Outcomes. One common reason given for health disparities is the problem of un- and under-insurance. However, according to *Unequal Treatment*, there is evidence of differences between minority and non-minority groups with the same type of insurance or in the same health plan. Even more compelling, when socioeconomic factors are equal for whites and minority groups, health care disparities remain. Understanding which gaps in health status for certain racial and minority groups actually stem from inequities in care is necessary before health care leaders and policy makers can effectively remedy health care disparities for these populations.

Figure 4

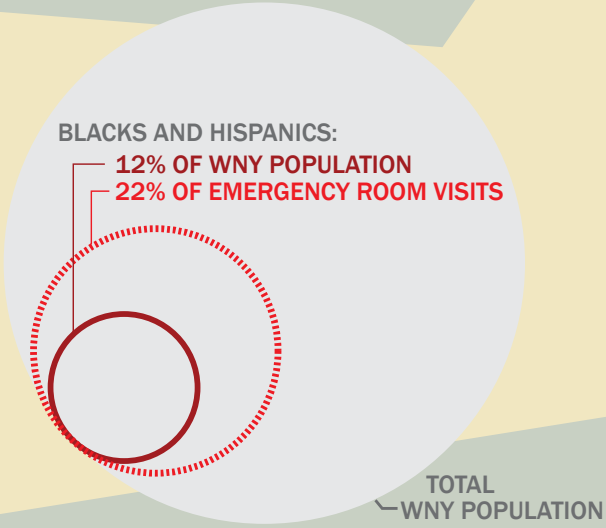
Conditions Related to Diabetes for Black and White Medicare Beneficiaries in Western New York

	BLACKS	WHITES	
Leg Amputation	1.96	.96	Black enrollees are about twice as likely as whites to have a leg amputated, with nearly two blacks per 1,000 enrollees losing a leg due to diabetes relative to one white per 1,000 enrollees.
	CASES PER 1,000		
Diabetics Having Healthy Levels of Blood Sugar (Hb A1C)	79%	84%	Annual examinations reveal nearly 84 percent of white enrollees with safe levels of Hb A1C, a measure of blood glucose levels, relative to about 79 percent of blacks.
DIABETICS AGE 65-74: Diabetics Having an Annual Eye Exam	61%	71%	Whites in the Medicare health plan receive more preventive care for this chronic health condition. Nearly 71 percent of whites age 65-74 have an annual eye examination while only 61 percent of blacks have this test taken; 90 percent of white enrollees age 65-74 receive an annual blood lipid test, compared to 85 percent of blacks.
DIABETICS AGE 65-74: Diabetics Having a Blood Lipid Test	85%	90%	

"Regional and Racial Variation in Health Care Among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project"

Figure 5

Emergency Room Visits for Blacks and Hispanics Relative to Total Western New York Population



New York State Department of Health, 2005 Hospital Emergency Departments of New York State

In Western New York, minority groups have experienced poorer health outcomes relative to whites despite having the same health care coverage. For instance, black diabetics receiving Medicare benefits are less likely to have preventive screenings than their white counterparts, contributing to the fact that they are more likely to be hospitalized for lack of treatment and to have a leg amputated **(Figure 4)**.

Minorities in Western New York – specifically blacks and Hispanics – are overrepresented in the number of visits to hospital emergency rooms. Blacks and Hispanics together comprise 22 percent of total visits but only 12 percent of the region's population (**Figure 5**). Frequent use of emergency rooms is due to many complex factors, not all of which are well understood at this time. While some use may be due to a lack of access to primary care or preventive care, many other factors play a role, including patient perception of acceptance by their physician, the burden of the pre-authorization process and scheduling difficulties.

Clinicians have identified a number of conditions for which hospitalizations could have been prevented by more timely and effective outpatient care. These conditions include poorly controlled diabetes and worsening heart failure. "Ambulatory care-sensitive" conditions are costly and often dangerous to the patient. In Western New York, the rate of such hospitalizations for black Medicare enrollees is more than 94 in 1,000 compared to only 76 in 1,000 for white Medicare enrollees **(Figure 6)**.

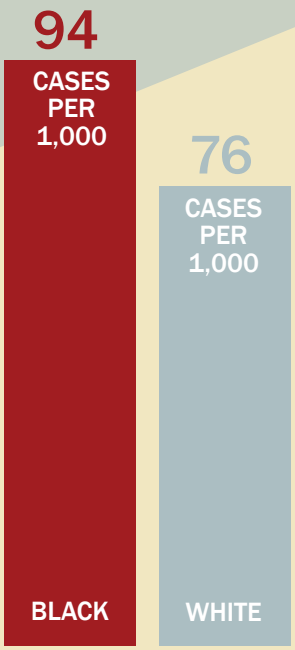


Figure 6
Hospitalization for Ambulatory Care-Sensitive Conditions in Western New York

"Regional and Racial Variation in Health Care Among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project"

Prenatal care is critical to the health of both the infant and the mother, providing the mother with information on diet, nutrition and infant care, and diagnosing health conditions for the mother and infant. Mothers who receive late or no prenatal care are more likely to have babies with health problems; the mortality rate for an infant receiving no prenatal care is five times the average. An assessment of the Western New York region reveals that blacks are more than twice as likely and Hispanics are 50 percent more likely than whites to receive late or no prenatal care at all **(Figure 7)**.

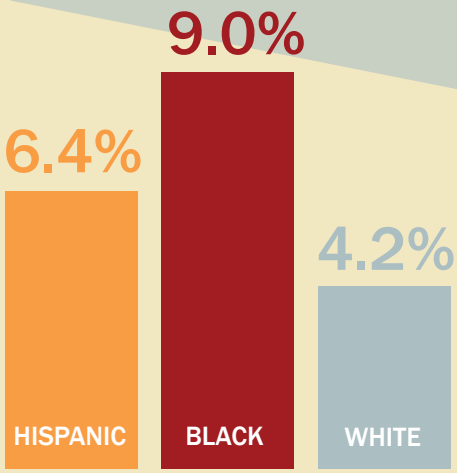


Figure 7
Percent Late or No Prenatal Care by Race/Ethnicity in Western New York

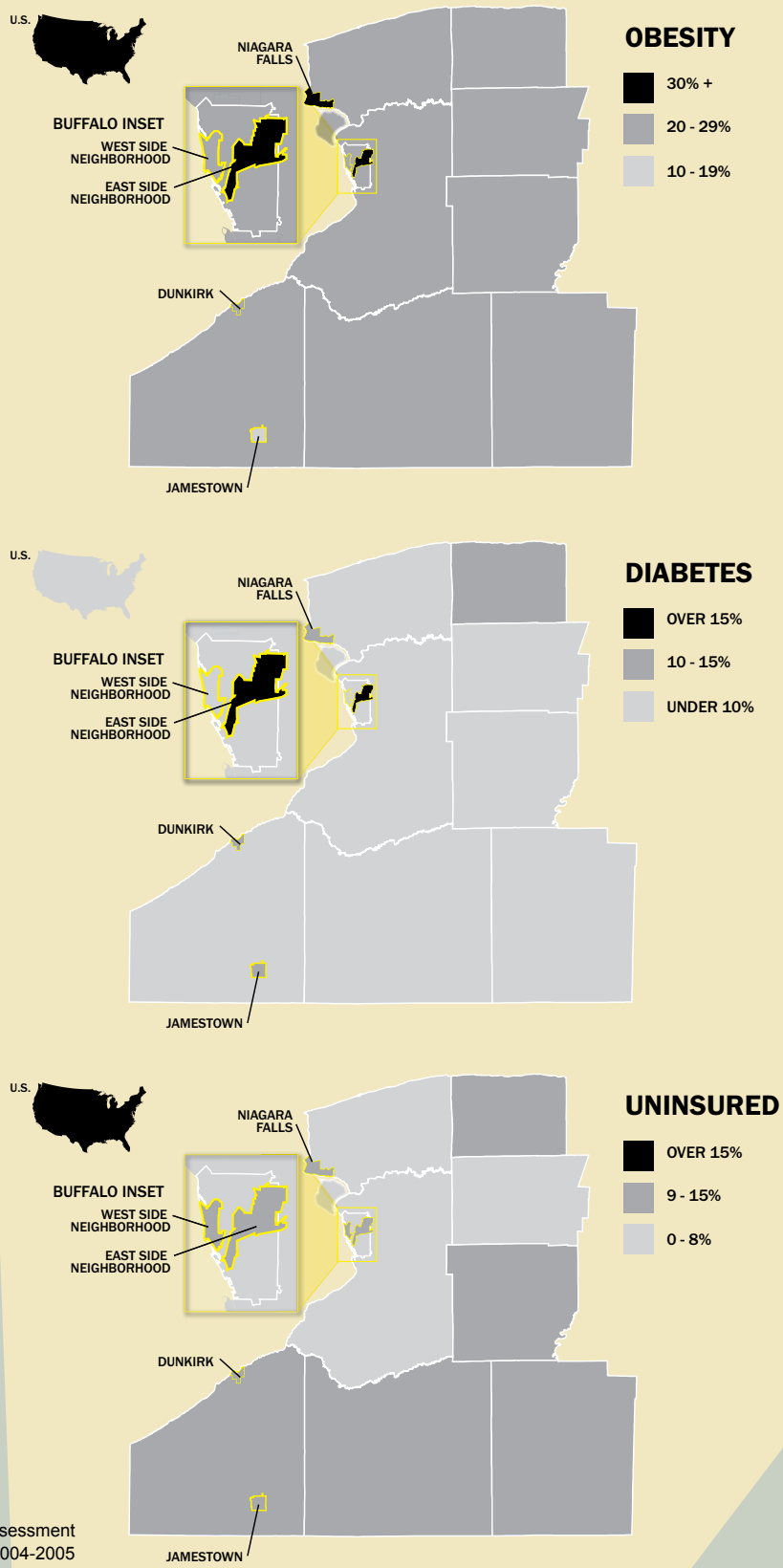
New York State Department of Health, 2006 Percent Late or No Prenatal Care, by Race and Resident County

Geographic disparities in health outcomes highlight additional inequities for the region's minority groups. Western New York's urban centers, where the concentration of minority populations is high, include the East Side and West Side of the City of Buffalo, Niagara Falls, Dunkirk and Jamestown. According to the 2004 Western New York Health Risk Assessment, these areas have a significantly higher prevalence of obesity, diabetes and individuals who lack health insurance **(Figure 8).**

The rate of obesity is highest for Buffalo's East Side, at 44 percent – well above the national rate of 32 percent. The challenge is also pronounced for Niagara Falls, where 31 percent of the population is obese. Notably, obesity rates for the rest of Western New York fall below the national average. The region's urban centers are uniformly above the national average in diabetes prevalence, with the rate for Buffalo's East Side more than twice as high and, in Jamestown, nearly twice as high. The proportion of the population in Western New York that is uninsured consistently falls below the national average, with rates in the region highest in some urban centers and several rural counties.

Figure 8

Prevalence of Key Risk Factors in Western New York's Urban Centers



The Western New York Public Health Alliance Health Risk Assessment Update, 2004-2005

Bridging Gaps in Care. Addressing racial and ethnic health care disparities requires a multi-pronged approach, including more targeted efforts to identify gaps in care and innovative programs for improving care quality. In 2006, the Disparities Solutions Center at Massachusetts General Hospital convened 20 experts in this field to determine an action plan and strategies for addressing care disparities. The results of this Strategy Forum, as reported by Dr. Roderick K. King, serve as a useful blueprint from which Western New York can take guidance.[2]

Among the Strategy Forum's key recommendations was for hospitals and health plans to consistently and routinely track patient race and ethnicity data to pinpoint differences in care quality. Yet research has shown data collection by the health system – health plans, hospitals and clinics – is neither standardized nor systematic, and that data sharing is limited. Western New York is not an aberration to this trend, as hospitals and health plans generally do not track this data in a consistent and comparable format.

Once disparities are identified, quality improvement interventions are critical to remedying care inequities. Health care leaders must continue to identify best practices, consider new approaches to quality intervention, develop incentives for their implementation and build broad awareness of the issue and related efforts, especially as it relates to securing the support of leadership and engaging minority communities. In Western New York, the health care community has undertaken several efforts to address gaps in care quality, including outreach to particular populations and neighborhoods and investing in overall improvements in quality of care.

The Road Ahead. As highlighted in the Strategy Forum, the nation still lacks a unified plan for moving ahead to narrow health disparities. In Western New York, efforts to date build an important foundation, but there remains a need for a more comprehensive, coordinated approach that builds upon past learning, aligns existing programs and monitors and reports progress. Moreover, the region lacks a shared vision for health equity among community, health and academic leaders.

During 2009, the P^2 Collaborative of Western New York and the Community Health Foundation of Western & Central New York will be supporting the development of *Health Equity in Western New York*, a diverse work group intended to coordinate and align existing efforts, fill important strategic gaps, measure progress and mobilize community support for reduction in disparities.

While more analysis of the issue is always helpful, local and national data have made a clear case of the scope and severity of racial and ethnic health care disparities. Across the country, communities are taking deliberate and strategic steps to collaboratively impact this systemic and unacceptable barrier to improved health and quality of life for everyone. It is time for us in Western New York to join them for the benefit of all people and communities.

Data Sources and Notes

Figure 1:
Population percentages by Race/Ethnicity are from the U.S. Bureau of the Census, 2000 Census, Summary File 1. Available at http://www.census.gov/Press-Release/www/2001/sumfile1.html.

Figure 2:
Median incomes by Race/Ethnicity are from the U.S. Bureau of the Census, 2000 Census, Summary File 3. Available at http://www.census.gov/Press-Release/www/2002/sumfile3.html.

Figure 3:
Socioeconomic Factors by Race/Ethnicity are from the U.S. Bureau of the Census, 2000 Census, Summary File 3. Available at http://www.census.gov/Press-Release/www/2002/sumfile3.html.

Figure 4:
Variation in care outcomes and risk factor prevalence for black and white Medicare beneficiaries are from: Fisher, E.S., Goodman, D.C., Chandra, A. 2008. Regional and Racial Variation in Health Care among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project. Robert Wood Johnson's *Aligning Forces for Quality (AF4Q)* Program. Available at http://www.dartmouthatlas.org/af4q.shtm.

Figure 5:
Black and Hispanic emergency room visits are from the New York State Department of Health, "2005 Hospital Emergency Departments of New York State," Tables 5 & 6. Available at http://www.health.state.ny.us/statistics/sparcs/ed/2005/.

Figure 6:
Hospitalization for ambulatory care-sensitive conditions for black and white Medicare beneficiaries are from: Fisher, E.S., Goodman, D.C., Chandra, A. 2008. Regional and Racial Variation in Health Care among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project. Robert Wood Johnson's *Aligning Forces for Quality (AF4Q)* Program. Available at http://www.dartmouthatlas.org/af4q.shtm.

Figure 7:
Percentages of population receiving late or no prenatal care are from the New York State Department of Health, "Percent Early and Late or No Prenatal Care, by Race/Ethnicity and Resident County – 2006," Table 12b. Available at http://www.health.state.ny.us/nysdoh/vital_statistics/2006/table12b.htm.

Figure 8:
Prevalence of obesity, diabetes, and uninsured from the "Western New York Health Risk Assessment (HRA) Update, 2004-2005, A Report on Behalf of the Western New York Public Health Alliance," Prepared by the Public Health Observatory and the University at Buffalo Department of Family Medicine (2005). Available at http://www.wnyhra.org.

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