Health Disparities at the Intersection of Race, Ethnicity, and Disabilities

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Guiding Question

It is well accepted that people who are members of racial and ethnic minorities experience significant health disparities.

What do you suppose happens when you add a disability to the mix?

How do you think people with disabilities, who are also members of racial and ethnic minorities, experience health disparities?

Learning Objectives

At the end of this session, participant will be able to:

1. Discuss societal trends, concepts, and challenges related to health disparities faced by people with disabilities.

2. Explain how disability-based health disparities at the intersection of race and ethnicity affect families, support personnel, and community-based providers.

3. Identify and share tools, methods, and approaches with families and others for effective advocacy to decrease disability-based health disparities

4. Share insights on how to negotiate with institutions and other professionals to decrease disability-based health disparities and increase effectiveness in their professional roles.
What does disability mean?

- Does not mean you are sick or unhealthy
- It is not a bad outcome
- It is a difference that people live with
- Limitations often come from without rather than from within
  
  Attitudes, lack of accessibility, etc.

What is a Health Disparity?

If a health outcome is seen to a greater or lesser extent between populations, there is disparity.

Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status and geographic location all contribute to an individual’s ability to achieve good health.

It is important to recognize the impact that social determinants of health have on health outcomes of specific populations.

Poll Question

Which do you associate with “disability”?

1. Illness or Health issue
2. Bad outcome from medical treatment
3. Physical or mental limitations people have
4. Limitations people live with
5. Limitations imposed upon people
Social Determinants of Health

Social determinants of health are conditions in the environments in which 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

- conditions (e.g., social, economic, and physical) in these various environments and settings (e.g., school, church, workplace, and neighborhood) have been referred to as "place." (IOM, 2002)

In addition to the more material attributes of "place", the patterns of social engagement and sense of security and well-being are also affected by where people live.

Examples include safe and affordable housing, access to education, public safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins.

SDOH

Understanding the relationship between how population groups experience "place" and the impact of "place" on health is fundamental to the social determinants of health- including both social and physical determinants.

New York Times 3/18/2018
Healthy People 2020 Approach to SDOH

What is Health Equity?

Healthy People 2020 defines health equity as the:

"attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities".

Current State of Disparities in the US

Disparities occur across many dimensions, including race/ethnicity, socioeconomic status, age, location, gender, disability status, and sexual orientation.

Disparities in health and health care affect everyone

They “limit overall improvements in quality of care and health for the broader population and result in unnecessary costs.”

Current State of Disparities in the US

Many groups are at disproportionate risk of being uninsured, lacking access to care, and experiencing worse health outcomes, including people of color and low-income individuals.


CLAS Standards

Health Care Providers must “[p]rovide 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.”


Percent of PWD

Disability is an emerging field within public health

People with significant disabilities account for more than 12% of the US population


Poll Question

People with disabilities:
1. Experience fewer health disparities because as a group they have more coverage (Medicaid, Medicare, etc.)
2. Experience the same health disparities as other underserved populations
3. Experience more health disparities because of physical or attitudinal barriers to care

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PWD Experience Health Disparities

“[p]eople with disabilities experience significant health disparities and barriers to health care, as compared with people who do not have disabilities.”

(PWD Meet the Criteria for Health Disparity Population

“The available evidence documents that people with disabilities meet all the criteria for a disparity population with disabilities were institutionalized and marginalized.

They experience documented differences in health outcomes at the population level that relate to higher rates of unmet health care needs, unhealthy lifestyle behaviors, mental health and chronic diseases, and social determinants of poor health.

Finally, many of these differences are recognized as avoidable and disproportionately affect this population.”

“People with disabilities are over-represented in many target populations for public health intervention - from smoking to obesity to injury prevention - yet their presence in these target groups is not recognized nor accommodated.”

“As a group, people with disabilities experience more chronic diseases and conditions, and experience them at earlier ages”
The Evidence....

3 out of 5 people with serious mental illness die 25 years earlier than other individuals, from preventable, co-occurring chronic diseases, such as asthma, diabetes, cancer, heart disease and cardiopulmonary conditions.

Inaccessible medical equipment and lack of trained physicians, dentists, and other health professionals prevent individuals with disabilities from receiving the basic primary and preventive care such as getting weighed, preventative dental care, pelvic exams, x-rays, physical examinations, colonoscopies, and vision screenings.

People who are deaf or experience significant problems hearing report they were 3 times as likely to report fair or poor health compared with people without hearing impairments. (NCH, 2009).

They have difficulty communicating with primary care providers who don’t want to pay interpreters or “bother” with a Telecommunication Device for the Deaf (TDD).

27% of adults with major physical and sensory impairments are obese, compared with 19% among those without major impairments (Iezzoni, 2009).

Individuals with intellectual disabilities must contact 50 physicians before they can find 1 trained to treat them (Corbin, Holdor, & Engstrom, 2005).

4.6% of deaf people are infected with HIV/AIDS.

50% of those with TBI or spinal cord injuries are substance abusers (Curtis & Heaphy, 2009).
1997 IOM report *Enabling America*:
- federal research effort in the area of disability was inadequate

2005 U.S. Surgeon General:
- issued a Call to Action and warned of the need to address disability-based health disparities in access to clinical care, prevention and wellness, and public health services

- research spending on disability is miniscule for future needs and numbers are likely to rise with aging baby boomers

CDC reports approximately 62 million (30%) Americans experience either some difficulty with “basic” movement, or cognitive, sensory, or emotional problems.

About 14% of people experience “complex activity limitations” in their ability to participate in society, including maintaining a household, working, and pursuing hobbies. (NHIS Data)

The Double Burden

“Aside from the public health issues that most racial/ethnic minorities face, minorities with disabilities experience additional disparities in health, prejudice, discrimination, economic barriers, and difficulties accessing care as a result of their disability—in effect, they face a “double burden.”

Amplifying Phenomenon

“Individuals from minority racial/ethnic groups who also have disabilities confront an enormous health disparity amplifying phenomenon.”


Challenging Multiplier Effect

“The combination of a racial and ethnic minority status with the presence of a disability creates a challenging multiplier effect in several areas of health.”


Disability in Racial & Ethnic Groups

Percent Who Have a Disability

Complex Activity Limitations

Percent with Complex Activity Limitations (among those with disability)

Perceived Health Status

Excl/Poor Health

Percent with Excl/Poor Health (among those with disability)

Military Families Learning Network

militaryfamilieslearningnetwork.org
Perceived Mental Health Status

Double Burden: Disability & REM

Persons with both mobility limitations and minority status experienced greater health disparities than adults with minority status or mobility limitations alone.

- worsening health
- depressive symptoms
- diabetes
- stroke
- visual impairment
- difficulty with activities of daily living
- obesity, physical activity
- low workforce participation (Altman & Bernstein, 2008)

Disability + REM

White people w/ Down syndrome in the US had a median death age of 50 in 1997

- median age was 25 for African Americans/Blacks
- median age was 11 for people of other races

(Friedman, 2001 CDC)

Disability + REM

African Americans are diagnosed more frequently with schizophrenia and less frequently with affective disorders compared with whites who exhibit the same symptoms. (SAMHSA, 2001)

Asians are more likely to be diagnosed with schizophrenia than whites, Blacks, or Hispanics. (Chow JC, Jeffe K, Snowden L 2003)

Only 27% of blacks received antidepressants when first diagnosed with depression, compared with 44% of whites. (SAMHSA, 2001)
Older Asian American women had the highest suicide rate - 6.01 per 100,000 - among older adult women of all racial-ethnic groups during 2005 and 2009.

There are many barriers to Asians seeking mental health including stigma, lack of language access, and lack of knowledge of community resources to mental illness goes unreported and untreated.

The 2001 Surgeon General’s report on mental health cited striking disparities in access, quality, and availability of mental health services for REM Americans.

African American/Black patients are prescribed fewer pain medications than whites. (Green et al, 2009)

People with serious mental illnesses (SMI) had 2 times higher obesity rate than the general population (59% vs. 24%).

People with SMI had 4 times the diabetes rate of the general population (25% vs. 6%)

Diabetes & obesity occurred together more frequently in the SMI sample: 78% compared to 31% of adults with diabetes only

African Americans had the obesity and diabetes combination at 3 times the rate found in non-African Americans.

African Americans and Hispanics with peripheral arterial disease and diabetes experience a greater incidence and odds of non-traumatic amputation between 1.5 and 4 times higher and at a higher amputation level when compared with non-Hispanic whites.

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Disparities in Diabetes

The rate of diagnosed diabetes by race and ethnic background:

- 15.9% of American Indians/Alaska Natives
- 13.2% of non-Hispanic African Americans
- 12.8% of Hispanics
- 9% of Asian Americans, and
- 7.6% of non-Hispanic whites


Aging & Personal Tasks

20% of African Americans/Blacks age 70+
lost the ability to perform personal tasks such as eating, dressing and bathing

17% of Latinos age 70+
lost the ability to perform personal tasks such as eating, dressing and bathing

15% of whites age 70+
lost the ability to perform personal tasks such as eating, dressing and bathing

(Peek, 2001)

Aging and Independent Living

23% of both Older African Americans and Hispanics
have difficulty performing household tasks like shopping, preparing meals and managing money that help them live independently

19% of Older Whites
have difficulty performing household tasks like shopping, preparing meals and managing money that help them live independently

Disparities Summary

- People with disabilities experience health disparities (Altman & Bernstein, HP2020)
- People who are members of racial and ethnic minorities experience health disparities (HP2020)
- PWD + MREM = greater health disparities (Drum et al., 2011)
Polling Question

What can you do to Decrease the Disparities?
1. Look at the environment
2. Train health care providers
3. Work on assertiveness training with PWD
4. Let PWD know what their rights are
5. Prevent secondary conditions

How Can We Decrease The Disparities?

Advocacy
- Recognize and accept them
- Collect demographic data on race, ethnicity, AND disability
- Use disability as a personal identifier and demographic
- Train providers
- Train community health workers

Effective Advocacy
- Focus on outcomes all patients need to achieve
- Identify the root cause of the problem
  - Lack of provider knowledge
  - Environmental barriers
  - Other attitudinal barriers
- Consider whether environmental changes are needed to achieve the desired outcome

Advocacy
- Train health care practitioners
- Work with PWD on assertiveness training and knowing their ADA & 1557 rights
- Make clients/patients aware of secondary conditions
- Help prevent secondary condition
Advocacy

• Accept PWD as a medically underserved population
• Stress inclusion in public health programs
• Improve quality and access to care
• Prevent secondary conditions
• Improve patient engagement and empowerment

Advocacy

Advocate for

– Accessible medical equipment
– The use of disability as a personal identifier and demographic
– Patient engagement opportunities
– Training providers
– Environmental access and barrier removal

Questions? Comments?

References


References


Iezzoni, L.I., (2009, January 27) Testimony before the Senate Health, Education, Labor, and Pensions Committee, by Lisa I. Iezzoni, MD, Professor of Medicine, Harvard Medical School and Associate Director, Institute for Health Policy, Massachusetts General Hospital, Boston, MA.


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