REDUCING DISPARITIES IN ELDERCARE

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Our nation and our health care system are grappling with the issue of health equity. We have identified factors that contribute to racial and ethnic disparities in health access, quality and outcomes, and are working to address them. Recognizing that unconscious bias can affect the doctor-patient relationship, health systems are providing training to help care providers be more aware of their biases and to develop skills of cultural competence. The social determinants of health are significant factors in health disparities, adding urgency to the need to improve education, dismantle poverty and make sure communities have healthy food options, quality housing and safe neighborhoods. And we slowly are acknowledging the pernicious effect of structural as well as individual racism in our society, particularly in the health of people of color. We have far to go, but we have begun the work.

When it comes to understanding and addressing health disparities in long-term care and eldercare, however, we are lagging behind. As the over 65 population increases in the next few decades, much of that increase will be due to the aging of racial and ethnic minorities. In 2015, about 22% of those over 65 were members of minority groups; by 2050 that will increase to 39%. We also know that in addition to significant income disparities based on race, there is a greater, and accelerating, gap between the median net worth of African-American and Latino families and that of white families.[1] The changing demographics and the racial wealth gap mean seniors seeking long-term care will be more likely to be racial or ethnic minorities and to have fewer resources to pay for their care. Aging minority seniors will have fewer choices about how and where to receive the long-term care they need.

We know there are racial and ethnic disparities in the quality of care nursing home residents receive.[2] Nursing home care is highly segregated. Over the past few decades, the number of minority nursing home residents has risen while the number of white residents has fallen. The shift has not been consistent across facilities, however. Racial and ethnic minorities are more likely to live in facilities with fewer resources, lower staff nursing ratios and lower quality indicators. Nursing homes with higher percentages of minority residents receive more citations for violation of health care and safety standards, though the gap may be narrowing.[3] A Minnesota study also found that quality of life scores were lower for residents in nursing homes with a higher proportion of minorities.[4] Racial and ethnic minorities are likely to receive lower quality nursing home care because they tend to live in nursing homes that provide lower quality care.

The facility-based disparities are well documented. Less is known about the existence of in-facility disparities — do minority residents receive the same quality of care as their white co-residents? Some studies have found no racial differences in care within a facility while others have detected disparities. One nationwide study found on average small but significant differences across eight quality measures, with wider variations in some facilities. However, the differences did not all go one way — in some cases white residents were favored, but in other cases minority residents were favored. More work needs to be done to stratify data by race and ethnicity. In the meantime, nursing homes could take steps to see if there are disparities of care in their facility and address them.

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The across-facility disparities raise two ques-

tions: how can we improve the care delivered in nursing homes with more minority residents, and what options do minority elders have when they need some level of assistance with activities of daily living?

A high concentration of minority residents correlates both with lower quality of care and greater dependence on Medicaid, which under reimburses for nursing home care. These facilities do not have the resources they need to improve quality. So one way to address nursing home health disparities is to improve Medicaid reimbursement. CHA's "Medicaid Makes It Possible" campaign is raising awareness about the important role Medicaid plays in providing care to millions of Americans, including older Americans. Protecting and improving the Medicaid program is key to ensuring quality nursing home care.

Because many people of color and other minorities have fewer financial resources, they have fewer choices when the time comes that they need help on a daily basis. Assisted living, continuing care retirement communities and private-home health care are expensive and inaccessible to seniors with lower incomes and fewer assets. This may be why there are more minority residents in nursing homes, both as a percent of the nursing home population and in relation to overall minority population. White elders have more access to alternatives to nursing home care than do minority seniors, highlighting another disparity in access to care.

There are initiatives underway to make it possible for states to pay for home- and community-based services and that could help address the disparities in access. However, researchers have begun looking at home health care quality, and several studies have found health disparities there as well.[5] Minority patients receiving home health care services have been found to have more adverse events, less functional improvement and worse patient experience. African-American and Hispanic patients receiving home health were found to be more likely to go to the emergency department or be readmitted to the hospital. As with nursing homes, indications are that home health agencies with a high number of African-American clients have lower quality of care scores.

Racial disparities exist in relation to end-of-life care and pain management as well. For example, African-Americans in hospice care are more likely to use the emergency department or to be hospitalized. Once again, the question is whether the cause is variation between facilities or within facilities. Some research indicates that differences exist between white and black patients in the same hospice,[6] but more research is needed on that issue and to see if there are differences among other minority groups. Furthermore, African-Americans are less likely to have advance directives or to enroll in hospice, and more likely to disenroll if they do.[7]

African-Americans and Hispanics are less likely to be assessed and treated for pain, and they find it harder to fill prescriptions for opioids due to lack of insurance coverage and because pharmacies in poorer or minority neighborhoods are less likely to carry opioids.[8] Current efforts to stem opioid abuse and addiction are warranted, but they could create an additional obstacle for minority patients who need those drugs for pain relief.

Religious and cultural differences, mistrust of doctors and the medical system, poor patient-provider communication and unconscious bias could all contribute to these disparities in end-of-life and palliative care. We do need additional research to understand these differences better, but in the meantime health care facilities, hospices and palliative care specialists are working to increase culturally appropriate education and outreach to minority communities about their pain management and end-of-life decision-making options.

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This outlines a pretty big agenda for addressing health disparities in long-term care and elder-care, but there is one more item to add. The legacy of racism in employment and housing ownership has contributed to income and wealth disparities, which in turn limit the long-term care options of minority elders. Patterns of housing segrega-

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tion contribute to the patient demographics of nursing homes and home health care agencies. A health care provider's unconscious bias can affect whether a patient's pain is assessed and treated.

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NOTES

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