Health Disparity in the Clinical World: Consequences and Solutions

Ahsan A. Naseem, MD, EMBA
Medical Director Bryan Psychiatry
Partner Cheney Psychiatric Assoc

1

Why I am here today

2

I told myself I will not be here today

Masters Political Science, Univ of Arkansas

Prof Univ of Baluchistan, Pakistan

Director Assoc of Muslim Women Parliamentarians

Retired

SECC Poli Sci and Sociology Adjunct Faculty

Member of volunteer groups to help indigent and refugee residents of Lincoln

3

Perspective of a physician

▪ Hysterectomy	1989
▪ ERT	2004
▪ Osteopenia and OP	
▪ Bilateral knee replacements	2008
▪ HTN	2009
▪ DM	2009
▪ Falls and TBI	2017
▪ Recurrent UTI and cystitis	2020
▪ Repeat hospitalizations	2023-4
▪ Acute Cardiac Failure	2024
▪ Acute urosepsis, ACF, RF	Sep 20, 2024

4

Risk Factors

Geriatric patient
Chronic medical conditions
Progressive decline

Immigrant (Asian)

Visible minority

5

Perspective of a POA

Does she speak English?
Mispronounced name

Loud and slow speech

No questions about cultural values:
- male attendants
- changing clothes in front of other women
- sponge baths
- dietary restrictions due to faith
- DNR status

Familiar with the name and preferences

Diet (pros and cons)

Faith and practices (Ramadan and prayers)

Travel plans to Pakistan

Humor and comfort level

6

What I learnt

Make them comfortable by getting to know them
Understand their preferences/expectations

Let them see you and understand you

When you see ignorance, challenge it
When you see unfairness, raise your voice

7

Inpatient “trapdoors”?

- Registration
- Transport to ED/floor
- Initial contact
- Med/procedure consent
- Initiation of care
- Inpatient stay
- Discharge planning
- Access to appointments and meds

8

Case Example 1

- A 29-year-old Caucasian female presents to the ED with c/o pelvic pain
- She has been experiencing symptoms for the last 3 days and cannot tolerate it any more

What are your initial thoughts?

What are her vulnerabilities?

9

Case example 1

- A 29-year-old Caucasian female from Belarus presents to the ED with c/o pelvic pain. The patient tells you she is a sex-worker and has had frequent unprotected sex for about 2 years now
- She has been experiencing symptoms for the last 3 days and cannot tolerate it anymore. She has no insurance and does not have a PCP

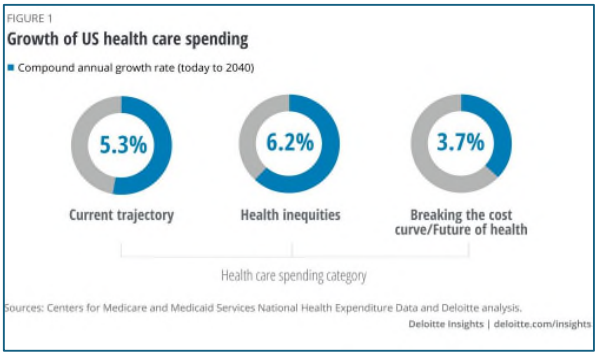
What are your thoughts now?

What are our vulnerabilities?

10

Yes, we should do better. But is there a business case for addressing health inequity?

- Health inequities account for $320 billion in annual healthcare spending
- If unaddressed, this figure would grow to $1 trillion by 2040
- Will cost an average American $3000/year vs. $1000/year now



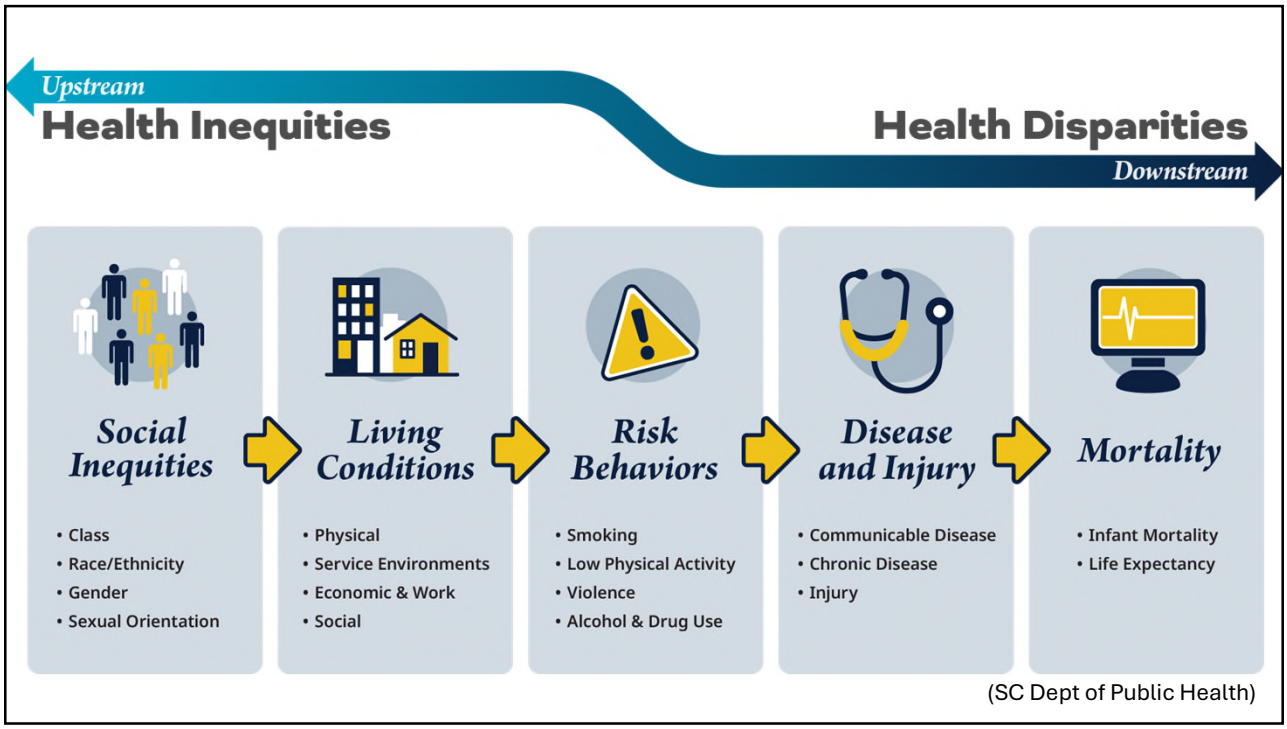
(Deloitte Insights June 2022)

11

"The underlying problem of health care spending is health inequity"

Pierre Theodore, MD
VP Health Disparities J&J

12



(SC Dept of Public Health)

13

Clinical impact of healthcare disparity: 2 examples

- Black adults are 60% more likely than white adults to be diagnosed with diabetes and two to three times more likely to have complications. Racial inequity often contributes to a late diagnosis and comorbidities.

- Public health researchers recently drew attention to two neighborhoods in Kansas City—Blue Hills and Armour Hills. In Blue Hills, people die an average of 14 years earlier due to social, economic, and environmental disparities compared to people living in Armour Hills.

(Deloitte Insights June 2022)

14

Case Example 2

- An 82-year-old male is brought to the ED by his son with complaints of severe back pain, burning in his urine and generalized weakness

What are your initial thoughts?

What are our vulnerabilities?

15

Case Example 2

- An 82-year-old Hispanic male who lives alone is brought to the ED by his son with complaints of severe back pain, burning in his urine and generalized weakness
- The patient lives in a rural town with population of about 900

What are your thoughts now?

What are our vulnerabilities?

16

Curse of the implicit bias

- Age
- Sex
- Race/ethnicity
- Weight
- Sexual orientation
- Religion
- Socioeconomic status
- Rurality

17

Social drivers of health and inequity

- Food insecurity
- Housing stability
- Physical activity
- Utilities
- Stress
- Financial resource strain
- Alcohol use
- Social connections
- Depression
- Transportation needs
- Tobacco use

18

Allostatic Load

- Stress faced by marginalized communities that manifests itself in anxiety, depression and eventually cardiovascular disease
- These stresses accumulate as a person's allostatic load that leads to a "weathering effect"
- Allostatic load can significantly affect the aging process and result in reduced longevity, accelerated aging, and impaired health
- Allostatic load is the "wear and tear" of the body resulting from the repeated activation of compensatory physiological mechanisms in response to chronic stress
- The weathering effect is not just felt medically, it is felt generationally

(Robeznieks et al 2023)

19

Rural population disparity causes

- Demographic shifts in which rural areas are losing population as young people migrate to cities for work, school, etc.
- Inefficiency associated with providing health care services, which leads to, for instance, hospital closures in rural areas
- Primary focus on and allocation of resources for interventions to address issues facing urban populations
- Lack of the necessary technological infrastructure (e.g., a lack of reliable Internet service), which limits the possible alternative strategies for health promotion
- Place-specific exposures such as those associated with mining and farming (pesticide exposures, etc.)

(NIH, National Library of Medicine)

20

Case example 3

- The 79-year-old male, with terminal cancer is being considered for Hospice care referral by the primary team
- His family is a strong support system for him

- What are your initial thoughts?
- Are there any vulnerabilities here?

21

Case example 3

- The 79-year-old male, a practicing Buddhist from China with terminal cancer is being considered for Hospice care referral by the primary team
- His family is a strong support system for him

- What are your thoughts now?
- What are our vulnerabilities?

22

So … What Can We Do

when inequity and disparity shows

23

Some thoughts from a physician & POA

For the patient:

- Recognize the challenge being faced by the patient
- Ask if they need assistance
- If we notice they are not understanding us, to gently explain

For the team:

- Education and awareness
- Case reviews
- Advocacy and identity
- Implicit bias awareness

24

Systems based approach

- Be intentional
- Form cross-sector partnerships
- Measure progress
- Address individual and community level barriers
- Build trust

(Deloitte 2022)

25

Mistakes are the portals of discovery

James Joyce (1922)

26

Service development

- Integrated care (PC, MH, CM) in OEF/OIF Clinics
- Pre-deployment education and post-deployment screens
- NE NG + VAMC family readiness programs and outreach
- Operational model across NE, then shared with VISN 23 (SD, ND, MN, IA) and eventually nationally
- Nebraska National Guard Homeland Defense Ribbon

27

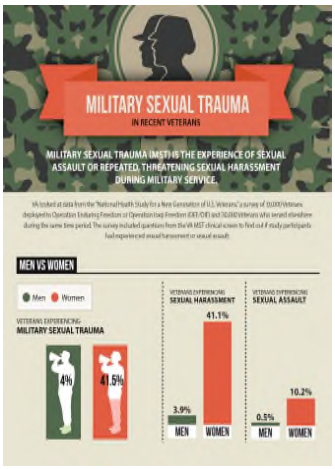
Confidence shatters

- About 18 months of operations first victim of sexual assault during deployment presents with alcohol abuse and near homelessness
- Nearly 1100 veterans from NE had returned from deployments
- The gross inadequacy of my approach

28

Magnitude of impact

- 21% of NE NG members are female
- 1100 veterans: 234 women
- 41% of sexual harassment: 95 veterans
- 10% of sexual assault: 23 veterans
- 4% of men with sexual harassment: 34 veterans
- 0.5% of men with sexual assault: 4 veterans



(Dept of Veterans Affairs 2015)

29

MY MISTAKE

- No post-deployment MST screening
- No planning for treatment of MST
- No care coordination for MST

- Infrastructure
- Clinical experience
- Integrated care model

DEFICIT IN AWARENESS

GROSS DEFICIT IN INDIVIDUALIZED CARE

30

ARTICLE IN PRESS

Military Sexual Trauma Among Recent Veterans

Correlates of Sexual Assault and Sexual Harassment

Shannon K. Barth, MPH,[1] Rachel E. Kimerling, PhD,[2] Joanne Pavao, MPH,[2] Susan J. McCutcheon, RN, EdD,[3] Sonja V. Batten, PhD,[4] Erin Dursa, PhD, MPH,[1] Michael R. Peterson, DVM, MPH, DrPH,[1] Aaron I. Schneiderman, PhD, MPH, RN[1]

Introduction: Military sexual trauma (MST) includes sexual harassment or sexual assault that occurs during military service and is of increasing public health concern. The population prevalence of MST among female and male veterans who served during Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) has not been estimated to our knowledge. The purpose of this study is to assess the population prevalence and identify military correlates of MST, sexual harassment, and sexual assault among OEF/OIF veterans.

Methods: MST was assessed in the 2009–2011 National Health Study for a New Generation of U.S. Veterans, a survey of 60,000 veterans who served during the OEF/OIF eras (response rate, 34%, n=20,563). Weighted prevalence estimates and AORs of MST, sexual harassment, and sexual assault among women and men were calculated. Gender-stratified logistic regression models controlled for military and demographic characteristics. Data analyses were conducted in 2013–2014.

Results: Approximately 41% of women and 4% of men reported experiencing MST. Deployed men had lower risk for MST compared with non-deployed men, though no difference was found among women. However, veterans reporting combat exposure during deployment had increased risk for MST compared with those without, while controlling for OEF/OIF deployment. Among women, Marines and Navy veterans had increased risk for MST compared with Air Force veterans. MST was significantly higher among veterans who reported using Veterans Affairs healthcare services.

Conclusions: These prevalence estimates underscore the importance of public awareness and continued investigation of the public health impact of MST.

(Am J Prev Med 2013;■(■):■–■) Published by Elsevier Inc. on behalf of American Journal of Preventive Medicine

The Influence of Military Sexual Trauma on Returning OEF/OIF Male Veterans

Sasha A. Mondragon
Michael E. DeBakey VA Medical Center, Houston, Texas, and Baylor College of Medicine

David Wang and Lonique Pritchett
Michael E. DeBakey VA Medical Center, Houston, Texas

David P. Graham, M. Leili Plasencia, and Ellen J. Teng
Michael E. DeBakey VA Medical Center, Houston, Texas, and Baylor College of Medicine

Military sexual trauma (MST) encompasses experiences of sexual harassment and/or assault that occur during active duty military service. MST is associated with postdeployment mental health, interpersonal, and physical difficulties and appears to be more influential in the development of posttraumatic stress disorder (PTSD) than other active duty experiences, including combat, among women veterans. Although some literature suggests that men who experience MST also evidence significant postdeployment difficulties, research in this area is lacking. The current study evaluated a large sample of returning male veterans (N = 961) who served in Iraq and/or Afghanistan. Veterans were referred for treatment in a trauma and anxiety specialty clinic at a large VA hospital. Of this sample, 18% (n = 173) reported MST perpetrated by a member of their unit. Results indicated veterans who reported MST were younger (p = .001), less likely to be currently married (p < .001), more likely to be diagnosed with a mood disorder (p = .040), and more likely to have experienced non-MST sexual abuse either as children or adults (p < .001). Analyses revealed that MST was negatively associated with postdeployment social support (p < .001 and positively associated with postdeployment perceived emotional mistreatment (p = .004), but was not associated with postdeployment loss of romantic relationship (p = .264), job loss (p = .351), or unemployment (p = .741) after statistically controlling for other trauma exposures and current social support. Results reflect the detrimental associations of MST on male veterans and the need for more research in this area. These findings also highlight the need for treatment interventions that address social and interpersonal functioning in addition to symptoms of depressive disorders.

Keywords: male veterans, military sexual trauma, mood disorders, postdeployment adjustment, substance abuse

31

Individualization

is the answer to

disparity

It is impossible for a man to learn what he thinks he already knows

Epictetus

32