Health Status, Care Management and Low-Income Seniors of Color

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Introduction

Elderly African Americans and Hispanics are more likely to have lower incomes and poor health status and to live with multiple chronic health conditions than their white counterparts.[1] The complex health status of these elderly individuals in communities of color requires proactive health care management to improve their health status and quality of life.

These vulnerable elders have much at stake in states that transition older populations into managed care programs. While offering an opportunity for much needed care management, careless implementation of these delivery systems will, at best, leave health disparities unchecked and, at worst, will exacerbate them.

This paper provides background information and data on the health status of low-income seniors of color and summarizes the critical ingredients of effective care management for low income seniors of color enrolled in a variety of managed care delivery systems.

Poverty among Elderly Communities of Color

In 2011, median family income for elderly African Americans ($22,738) and Hispanics ($22,126) was significantly lower than for elderly whites ($34,113).[2] While only 6.8% of whites 65 and older lived below poverty, 11.7% of Asians, 17.1% of blacks, and 18.7% of older Hispanics had incomes below the federal poverty level.[3]

Like the general population, Medicare enrollees from communities of color are more likely to live in poverty or near poverty. Consequently, older adults of color are much more likely to also be eligible for Medicaid, the program that covers individuals with low incomes. Individuals enrolled in both Medicare

and Medicaid are known as "dual eligibles." Persons of color make up fully 45% of the elderly dual eligible population, while they constitute only 15% of the non-dual Medicare population.[4] Among minority populations, 18% of elderly dual eligibles are African American, 18% are Hispanic, and 9% report a different race or ethnicity.[5]

Health Status and Multiple Chronic Conditions in Elderly Communities of Color

Health Status

The impacts of socioeconomic disparities are reflected in health profiles of older adults of color. Relative to non-Hispanic whites, they face a higher incidence of many of the most devastating health threats for older adults, including diabetes, hypertension, and Alzheimer's disease.[6] Many of these conditions are chronic health conditions, or reoccurring health issues that last for periods of months and years.[7] Although some chronic health conditions are manageable, they require ongoing monitoring and treatment and can alter an individual's quality of life.[8] Disparities in reliable access to affordable care over time could very well lead to divergent health outcomes.

> *…Over 30% of elderly Hispanics and blacks suffer from diabetes, compared to 18% of elderly non-Hispanic whites.*

One study shows that over 30% of elderly Hispanics and blacks suffer from diabetes, compared to 18% of elderly non-Hispanic whites.[9] Foot problems often indicate larger underlying health concerns, such as poor circulation and diabetes. The data for Medicare enrollees indicates that that Hispanic (60.8%), black (59%), and multiracial (59%) elderly had significantly higher prevalence rates for this indicator than whites (40.4%). Table 1 shows prevalence rates for these and other selected health conditions. Table 1 also demonstrates that Medicare enrollees from communities of color were more likely to report poor health status. For example, almost all of the included communities of color reported higher prevalence of symptoms of chest pain, shortness of breath, and arthritis than white participants. Every group measured also reported more problems with vision and hearing than whites. In addition, prevalence rates for symptoms of depression for most communities of color were above 20%, and as high as 27% for Hispanics, while the rate was only 11.7% for elderly white Medicare enrollees.

Table 1: Self-reported Prevalence of Adverse Health Outcomes Among Elderly Medicare Health Plan Members, by Race/Ethnicity (2012)[10]

Reported Factors*	White	Hispanic	Black	AI/AN	Asian	NH/PI	Multi-racial
Foot symptoms in last 4 weeks	40.4%	60.8%	59%	55.4%	52.4%	58.3%	59%

Chest pain symptoms in last 4 weeks	22.7%	39.9%	37.4%	37.2%	34.9%	40.4%	38.6%
Shortness of breath in last 4 weeks	50.5%	62.1%	63.3%	64.1%	50.6%	62.8%	62.7%
Severe or moderate arthritis pain in last 4 weeks	33.3%	46%	44.1%	42.5%	27%	36.7%	39%
Depressed mood much of the time in last year	11.7%	27%	20.9%	22.3%	15.3%	22%	22.1%
Vision problem	5.6%	14.5%	11.2%	11.2%	10.5%	10.9%	11%
Hearing problem	12.9%	22.2%	16.2%	20.1%	17%	22.1%	15.6%
1 or more ADL Impairments	35.3%	45.7%	46.5%	49.3%	31.9%	41.9%#	47.8%

AI/AN = American Indian/Alaskan Native NH/PI = Native Hawaiian/Pacific Islander
ADL = Activity of Daily Living

* All differences between ethnic/racial categories are significant to P<0.003.
# Misreported in the original. Corrected figure listed here.

African Americans are diagnosed with cognitive impairment at two to three times the rates of elderly whites.[11] Dual eligibles are also more than twice as likely to suffer from a mental illness.[12]

In addition to clinical problems, elderly communities of color more frequently experience functional limitations. Older adults of color more commonly face difficulties performing at least one activity of daily living ("ADL"), such as bathing or getting dressed.[13] The prevalence rate for Medicare enrollees having difficulty performing one or more ADLs was highest for American Indians/Alaskan Native elderly persons (49.3%), followed by multiracial individuals (47.8%), blacks (46.5)%, Hispanics (45.7%), and Native Hawaiians/Pacific Islanders (41.9%), while only an estimated 35.3% of white enrollees had difficulty performing one or more ADLs.

Not only do older adults of color suffer from more health conditions, but these conditions are often diagnosed later, with more severe onset and complications.[14] For example, elderly African Americans obtain later diagnoses for Alzheimer's than their white counterparts.[15] Disparities in access to health care and insurance play a contributing role in such diagnosis delays.[16] This "double jeopardy" of poorer health status compounded by reduced access to care makes health disparities for older adults particularly severe and challenging to address.[17]

Multiple Chronic Conditions

Among elderly individuals, chronic conditions are the rule and not the exception. Data shows that 88% of individuals aged 65 to 74 years old and 92% of individuals over age 85 have at least one chronic health problem.[18] To make matters much worse, a majority of elderly individuals manage *three or more* chronic conditions.[19]

Among certain Medicare enrollees age 65 and older, women and people of color have high incidences of multiple chronic conditions. Table 2 demonstrates that among elderly women, 46.7% of blacks and 46.4% of Hispanics live with four or more chronic health conditions (considerably higher than the rate

for non-Hispanic white women). About 40% of black men live with four or more chronic health conditions.

The poor health status of older adults of color, together with the frequent and complicated incidence of multiple chronic conditions, creates serious challenges for their care.

Table 2: Percentage of Medicare Fee-for-Service Enrollees, 65 Years of Age and Older and Number of Chronic Health Conditions, by Race, Ethnicity, and Sex (2010)[20]

MEN	NUMBER OF CHRONIC CONDITIONS (%)		
	0 or 1	2 or 3	4 or more
Non-Hispanic White	30.4	31.7	37.9
Non-Hispanic Black	31.5	28.3	40.2
Hispanic	36.9	26.0	37.1
Non-Hispanic Asian Pacific Islander	32.1	33.0	34.9
Non-Hispanic American Indian/Alaska Native	33.1	29.8	37.1
Non-Hispanic Other Race	37.8	30.9	31.3
WOMEN	**NUMBER OF CHRONIC CONDITIONS (%)**		
	0 or 1	2 or 3	4 or more
Non-Hispanic White	27.2	34.5	38.5
Non-Hispanic Black	20.5	32.9	46.7
Hispanic	24.8	28.9	46.4
Non-Hispanic Asian Pacific Islander	27.8	35.3	36.9
Non-Hispanic American Indian/Alaska Native	27.6	33.0	39.4
Non-Hispanic Other Race	34.3	33.1	32.6

Other Critical Socioeconomic Factors for Elderly Communities of Color

In addition to poverty, other socioeconomic factors contribute to the persistent health care disparities and poor health status of elderly communities of color. As shown in Table 3, African Americans were significantly more likely to be living alone than either whites or Hispanics.[21] This raises significant challenges for managing chronic conditions, especially if the individual living alone is cognitively impaired and living without an identified caregiver.[22] Such individuals are at greater risk of poor health than those who live with others, due to malnutrition, missed medical appointments, and untreated health conditions.[23] Moreover, these individuals are at risk of serious injury or accidental death because of falls or decreased recognition of dangers.

Among certain Medicare enrollees age 65 and older, women and people of color have high incidences of multiple chronic conditions.

Table 3 also shows that older adults of color are much more likely than whites to have less than 12 years of education – more than twice as likely in the case of African Americans and Hispanics interviewed in English, and more than three times as likely for Hispanics interviewed in Spanish. This education gap also predicts lower health literacy, which inhibits an enrollee's ability to research health care options, understand complex health plan materials, adhere to treatment or wellness plans, or engage in other activities, such as managing medications.[24]

Table 3: Selected Characteristics of Individuals 65 Years of Age and Older without a Disability at Baseline (1998)[25]

DEMOGRAPHICS	AFRICAN AMERICANS	HISPANICS INTERVIEWED IN SPANISH	HISPANICS INTERVIEWED IN ENGLISH	WHITES
Living Alone	36.03%*	20.47%**	30.51%	30.85%
Poor Vision/Legally Blind	8.85%**	10.28%**	8.34%*	4.35%
Functional Limitations (Physical)	38.16%**	43.76%*	31.03%	26.36%
SES Status: • < 12 years of education	59.21%**	82.56%**	52.17%**	25.80%
• Low net worth (lowest quartile)	52.44%**	66.42%**	41.51%**	15.74%

* P<0.05; ** P<0.01(unadjusted)

Language

Some elderly people of color are more likely to encounter language-related barriers to care. In one study of disparities in older adults' access to physician services, only 44% of Hispanic participants responded in English, compared to 100% of African Americans and whites.[26] The study represented in Table 3 tracked participants without disabilities over six years to examine their relative risk of developing disabilities. In that time, overall risk of disability onset was significantly higher for limited English proficient Hispanics (32.7%) than it was for English proficient Hispanics (20.0%).[27] Access to appropriate language services is, thus, a vital component for care management in certain communities of color.

Importance of Managing Multiple Chronic Conditions

The racial and ethnic health disparities facing older adults – a result of the combination of increased poverty and socioeconomic challenges, poorer health status that includes higher incidences of multiple chronic conditions ("MCCs"), and increased barriers to care – create serious difficulties for improving the health of these adults and reducing health disparities. Without appropriate care management, MCCs can seriously erode both health status and quality of life for low-income elderly individuals of color.

For example, untreated diabetes often leads to cardiovascular disease.[28] Those with poor or no management of diabetes also risk developing other complications, such as eye disorders, skin ulcerations, and amputations.[29] The literature consistently shows that increased adherence to treatments for chronic conditions, such as taking antihypertensive medications to lower blood pressure

or controlling blood sugar with insulin for diabetics, significantly improves health outcomes.[30] Specifically, greater adherence correlates with fewer hospitalizations and often with reduced emergency department utilization.[31] Elderly individuals with MCCs experience an elevated risk of hospitalization generally and therefore represent a critical target population for improving treatment adherence.

The higher risk of hospitalization for older individuals with MCCs underscores the importance of effective transition planning between different care settings. This should be a fundamental component of any care management program for older adults. Studies show that such transitions are often poorly managed, and miscommunications or failures to follow-up can lead to poorer outcomes and preventable hospital readmissions.[32]

Those with poor or no management of diabetes also risk developing other complications, such as eye disorders, skin ulcerations, and amputations.

Finally, care management should help older individuals avoid *developing* serious health conditions in the first place, through preventive screenings to identify potential problems early on. In a nationally representative sample of adults reporting moderate to severe depressive symptoms, over half received no treatment.[33] African Americans, Mexican Americans, and individuals over the age of 80 in this group were even less likely to receive treatment.[34] Untreated depression can exacerbate other illnesses, contribute to premature death or suicide, and increase the likelihood of other disabilities.[35] Moreover, less than half of adults aged 65 and older have received recommended clinical preventive services and screenings, such as influenza and pneumococcal vaccinations and screening for lipid disorders, colorectal cancer, and breast cancer.[36] For people of color in this age group, the evidence of lack of preventive screenings is stark. For example, a 2010 survey showed that while 65% of non-Hispanic white seniors reported ever receiving a pneumococcal vaccination, only 39% of non-Hispanic blacks and 35% of Hispanic seniors indicated they had received that vaccination.[37]

High Stakes for Elderly Individuals of Color

Given the gravity of the health care challenges facing older adults of color and the potential for health care management to improve these disparities, care management is truly a race and ethnicity issue. As health care delivery systems are remodeled to address "cost" and "quality," there are opportunities and risks, and the heath security of elderly communities of color hangs in the balance.

Opportunities

Lower income older adults, who are disproportionately people of color, have much to gain from properly coordinated, team-based, person-centered managed care approaches.[38] As noted above,

African Americans, Hispanics and other ethnic and racial populations constitute a disproportionate share of the chronically ill and are thus more likely to benefit from effective health care management. This might help to reduce some of the health and health care disparities accumulated across a lifetime of inequities.[39] Medicare and Medicaid have numerous initiatives underway to test new models of care management that may substantially impact the older adult population of color:

- The HHS Medicare & Medicaid Coordination Office ("MMCO"), created by the Affordable Care Act, has undertaken a major effort to improve integration of Medicaid and Medicare through projects in up to 18 states.[40] It is important that organizations that advocate for communities of color and aging populations engage with MMCO to promote meaningful care management.

- Some state Medicaid programs and certain MMCO projects are based on Primary Care Case Management ("PCCM") systems that use patient centered-health teams. PCCM generally reimburses primary care providers with extra payments to invest in and coordinate the care teams, but retains a fee-for-service ("FFS") payment methodology for other services.

- Medicare, and to a lesser extent Medicaid, is also experimenting with other models of care, such as Accountable Care Organizations and Bundled Care programs.[41]

Risks

While older adults of color stand the most to gain from care management, they will lose ground where care management is poorly implemented. We will highlight two serious risks.

First, some states are rushing to implement new care management programs, with large populations of older adults being enrolled in rapid succession. This has the potential to create serious confusion and care continuity problems. For example, an older adult may have a long-standing set of providers (e.g., doctors, nurses, home attendants, medical suppliers, etc.) who may not participate in or may be excluded from the new care system. As another example, the older adult may be in the middle of a successful treatment plan that the new health care plan wants to alter or discontinue. The transitions to new systems represent continuity of health care risks for older adults who may have a delicate health status and a carefully arranged treatment team and plan.

Second, the new models of care raise longer-term concerns about health care incentives. For example, many of the new models of care are based on "capitated" managed care models – where managed care companies receive a fixed monthly payment for every enrollee. Some believe this encourages managed care companies to provide quality care in the present to reduce future health costs, while others believe it results in managed care companies denying care in the present. Moreover, while communities of color are generally overrepresented in capitated Medicare Advantage plans, the literature gives no consistent picture as to whether these plans are significantly addressing existing health inequities. For example, Trivedi et al. found that from 1997 to 2003, disparities in Healthcare Effectiveness Data and Information Set ("HEDIS") outcomes decreased in seven categories, but increased for glucose and

cholesterol control.[42] Basu found that disparities in preventable hospitalizations were marginally lower (7-18%) for individuals in Medicare Advantage than in FFS Medicare.[43] However, large disparities persisted. Other studies of enrollee care experience have revealed substantially poorer results for black and Hispanic Medicare Advantage patients relative to whites in most categories.[44] These racial and ethnic disparities in self-reported experience are in many areas larger in Medicare Advantage than in FFS Medicare.[45]

Reversing Disparities through Care Management

The need for improved care management is clear and many of the components for effective, person-centered care management are known. To reduce disparities for older adults, care management must develop and maintain:

- robust and accessible provider networks that include an adequate array of geriatric specialists and long-term care providers;
- continuity of care that ensures that older adults who are transitioned into new systems of care can continue to receive their on-going treatments with their existing providers, at least during a period of careful transition;
- multifaceted care coordination teams that empower individuals to take charge of their own care and promote communication among individuals' various providers, caregivers, case managers and family members;
- effective and consistent systems for care setting transitions (e.g., discharges from the hospital to home) that ensure adequate follow-up care;
- mechanisms to reduce common barriers to care faced by elderly communities of color, including isolation, health literacy, access to nonemergency transportation, and the lack of culturally and linguistically appropriate services;[46] and
- clear and robust due process protections to ensure that enrollees can navigate the system and receive all the needed services to which they are entitled.

New care management systems must also address one final critical factor to reverse the inequities in health care access faced by communities of color. Because more elderly African Americans and Hispanics are living in poverty than their white counterparts, cost sharing represents one of the most significant barriers to care that can exacerbate health care disparities.[47] The cost sharing literature shows that individuals with chronic conditions, particularly the elderly are particularly sensitive to cost sharing requirements, such as deductibles and copayments.[48] Any care management program that affects older adults of color must take into account the out-of-pocket burden on lower-income beneficiaries if it is to reduce health disparities.

Conclusion

Advocates for communities of color and the aging must recognize the connection between health care delivery system reform and race and ethnicity to address health and health care disparities. Seniors of color are more likely to live in poverty and with multiple chronic conditions that, if poorly managed, could result in further disability, injury, or death. Tremendous potential to either improve or degrade the health security of older adults of color lies in the exploration of new models of health care management. Furthermore, as the nation's population ages, the representation of Hispanic and African American elderly will only *increase*, which underscores the urgency to strengthen efforts for coordinated care management.[49] Otherwise, the health care delivery system will continue perpetuate the unacceptable disparities that plague our current system.

ENDNOTES

[1] All data references cited in this report reflect the original terms and populations used in the specific studies. Generally, disparities research uses either "African American" or "Black" to refer to the black population in the U.S., and "Hispanic" for individuals who self-identify across a range of Latino identities.
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