Mario J. Paredes
Chief Executive Officer
mparedes@somoscommunitycare.org
646.979.7613

Transforming Health Care for Minorities and The Poor

4/21/2022

It bears repeating that the COVID-19 pandemic laid bare in stark relief the still significant gap separating the quality of health care enjoyed by white and affluent American from that made available to minorities and the poor.

As all of you know, the figures are startling. At the height of the pandemic, research showed that Hispanics made up 29 percent of the population in New York City but suffered 34 percent of all deaths from Covid-19. African Americans made up 22 percent of the population and suffered 28 percent of deaths. White Americans made up 32 percent of New York City's population but had 27 percent of deaths. Other minorities also suffered disproportionately during the pandemic.

Underlying this morbidity and mortality were the primary medical conditions—diabetes, obesity, hypertension, cardiovascular disease—that made minorities far more vulnerable to the virus. In still far too many cases these conditions among poor minorities with no or poor health insurance go undetected and untreated, or they are treated with insufficient care or consistency. Such is the harsh reality of inequities in health care affecting racial and ethnic minority communities in the US, with the poorest among them suffering the brunt of the neglect and discrimination.

Many argue that this lack of equitable access to health care can be largely blamed on structural racism of US health care policy, which shapes the many ways in which health care in the US is structured to give benefits to the white population at the expense of racial and ethnic minority populations. Thus, racism is built into the system. And in many ways, of course, it definitely is. Significant fall-out of the biased system is found in the realm of health insurance. Research has shown that racial identity is linked to a lack of health insurance, while low-income minorities suffering poor health are almost 70 percent more likely to have no health insurance than affluent whites who are in good health.

Also, those racial and ethnic minorities that do have insurance are disproportionately covered by employers whose plans offer relatively poor coverage. Many of these employees are not eligible for Medicaid, nor for federal subsidies through the Affordable Care Act. They are stuck with subpar health insurance and potentially large out of pocket expenses in the case of significant illness.

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For example, whereas the average family spends about $8,000 or 10 percent of the annual income on health insurance premiums, for African Americans that figure stands at almost 20 percent of annual household income—a huge difference considering income disparity. High costs lead many minority families to remain underinsured. Of the nation's 87 million underinsured people, 18 percent are African American.

Today, discrimination on the basis of race or ethnicity is illegal, but nefarious practices continue in the form of hospitals and other medical institutions discriminating against patients based on insurance status, a practice which disproportionately affects non-white communities.

Plus, across the board, studies find that, compared to whites, Hispanic and black patients are less likely to be given evidence-based cardiovascular care, kidney transplants, age-appropriate screening for breast and colon cancer, timely treatment for cancer and stroke, treatment for reported pain, preventive care across the board, as well as effective and appropriate mental health care. The system seems rigged!

This is hard to believe, but as recently as 2016 a study found that many white medical students believed that black people have a higher tolerance for pain than white people, under the assumption that blacks have thicker skin, less sensitive nerve endings or stronger immune systems. Such shocking beliefs go back to the nineteenth century, with roots in the mistreatment of African slaves. A whopping 73 percent of medical students surveyed reported at least one erroneous belief regarding biological differences between races. Clearly, in our society, the perception of racial and ethnic minorities still labels them as unwanted outsiders. We must all join forces to bring about genuine, lasting health care reform.

For many of us the battle will take place in the health care establishment, others will advocate in the political arena, still others, through communication efforts, will aim for engaging the public in the cause to eradicate racial and ethnic discrimination in US health care.

For SOMOS Community Care, a network of 2,500 community-based doctors providing minorities and the poor in New York City with superior health care, while active in all these various arenas, the primary focus has been to improve the quality of publicly funded health care for the poor: Medicaid reform. Our experience shows that hard work, dedication, and smart spending can offer the neediest patients—with racial and ethnic minorities disproportionately represented—excellent, life-changing health care.

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SOMOS got its start in 2014 thanks to an innovative Medicaid program launched by the New York State Department of Health, called the Delivery System Reform Incentive Payment program. DSRIP has demonstrated the viability of upending traditional Medicaid by offering patients superior care, including preventive care at lower cost—the best of both worlds.

First, traditional Medicaid is not very patient-friendly. Seeking care, recipients often find themselves in a maze, with lots of red tape, difficulty making appointments and much waiting time. This model does not produce careful oversight and coordination of a patient's overall medical and behavioral care. SOMOS is offering patients a one-stop portal to access all the care needed, with the primary care doctor overseeing and carefully recording data on patients' overall care.

This model presumes a dedicated physician. That dedication is rewarded by the core formula of DSRIP: Value-Based Payment (VBP). Traditional Medicaid—prone to waste and fraud—pays doctors for discrete procedures, services rendered, an office visit, a test, etc. The Value-based Payment formula stipulates doctors are compensated according to the longer-term health outcomes of patients; the better the patients do, the greater the compensation for the provider. Hence, the cultivation, the construction of a holistic, comprehensive plan of action that takes into account all the needs of a patient.

Among those needs, beyond the strictly medical, are those dictated by social factors, such as poverty, unemployment, sub-par housing, etc. These are known as Social Determinants of Health and they are a key indicator as to the needs and challenges of patients, especially for the most vulnerable among them. SOMOS doctors rely on teams of Community Health Workers, who visit patients' homes and are doctors' eyes and ears in the community. Traditional Medicaid often provided through hospital-based corporate medical entities is simply not able to flag social issues in the lives of patients.

The 2,500 SOMOS doctors (most of them primary care doctors)—serving more than 700,000 African Americans, Asian Americans, and Hispanic Americans in New York City—also have a cultural and ethnic affinity with their patients, in whose very neighborhoods they themselves live and work in many cases.

In sum, with doctors having intimate knowledge of their patients' lives, a genuine doctor-patient bond of trust is created—which holds the key to treatment success. Testimony to that success? Savings for New York State taxpayers of more than $300M thanks to SOMOS doctors reducing by 25 percent unnecessary trips to the ER and unnecessary hospitalizations.

The end of the five-year DSRIP mandate coincided with the start of the pandemic. SOMOS again focused on poor minorities by setting up and running testing sites at schools as well as at neighborhood churches, catering to an underserved population.

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SOMOS did the same when it got the go-ahead to administer the vaccine at neighborhood-based doctor's practices, thus again helping underserved minorities who were hard-pressed to make appointments on often confusing websites. As trusted figures, much like the family doctors of old, SOMOS doctors are also able to help overcome patients' doubts and concerns about getting vaccinated.

SOMOS doctors are reaping the rewards of their hard work, as patients flourish thanks to excellent care. Smart spending holds the key to DSRIP and SOMOS has high hopes that there will soon be a DSRIP 2.0 to continue to transform health care for poor minority communities. It can be done and the SOMOS model can be replicated elsewhere in New York State or even nationally. Significant savings and magnificent results are a great incentive.

In the end, what must drive us in combatting racial and ethnic discrimination in health care is what Archbishop Vincenzo Paglia, president of the Pontifical Academy for Life, in a recent talk at SOMOS headquarters, described as the Church's social doctrine, which gives "a central place to the human person and human dignity, and to the goal of relationships based on solidarity and justice."