What if your father struggles with arthritis – and you are a physician? Featuring Michael Parks.

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When an accomplished surgeon sees his own father struggle with arthritis, he knows there are some structural problems in play. HSS surgeon Dr. Michael Parks shares some insights into the processes behind health disparities (or health differences as he prefers to say). Why do some people steadily progress through the steps of intervention, but others languish? What role does race and gender play? Dr. Parks also discusses why the WHO sees health disparities as a social injustice, and why a new bill sponsored by Congressman John Lewis is so important to health equality. With Bill Finerfrock.

Bill Finerfrock: Hi. You're listening to the Health Disparities Podcast from Movement is Life, conversations about health disparities with people who are working to eliminate them. I'm Bill Finnerfrock and today I'm discussing health disparities and health policy with Dr. Michael Parks who is the Associate Attending Surgeon at Hospital for Special Surgery in New York City and he's also a member of the executive committee of Movement is Life. Thanks, Dr. Parks for taking some time to talk with us today. Tell us a little bit about yourself and how you got involved with Movement is Life and in particular, the issue of health disparities?

Dr. Parks: Well, they actually are one and the same. I actually watched a member of my family, my father struggled with progressive arthritis and it was very frustrating to me to see someone who had access, who had insurance, who had education, an Ivy League level master's degree, and even a son who was in the business, and I watched him progressively become more and more immobile due to pain from arthritis. At the same time in my professional life, I saw patients with the same disability and affliction who refuse treatment that I knew was effective and commonplace and they were simply, I thought afraid, or I really didn't know what it was. So, at that time, we got a small grant and we looked at attitudes. How patients made decisions about surgery. And that was how I became involved. At the same time, Movement is Life with Verona Brewton, being appointed in charge of a segment at Zimmer, a group of us started working with her and we began to work together to understand disparities in healthcare and most specifically disparities in osteoarthritis and joint replacement as I am a joint replacement surgeon. Then, I think, now we've probably transitioned to not only understanding but how can we intervene and how can we perhaps positively offset those disparities that exist.

Bill Finerfrock: So, what is a health disparity and particularly as it relates to socioeconomic or social determinants, those factors, what is a health disparity?

Dr. Parks: You're asking a loaded question. I give an hour-long talk and I have a slide.

Bill Finerfrock: We don't have that much time.

Dr. Parks: That is really full. But it depends on who you talk to. So, one of the first papers that we published, the editor sent us back and said, don't just say disparity, say difference. And so, I looked up all these different definitions. What is healthcare disparity? So, there are numeric definitions by scientific organizations like the AHRQ that maybe it's a 10% difference between populations and how they receive healthcare. But then the World Health Organization has a very interesting definition and sees it as a social injustice. So, if there is a difference between how two major league basketball players received care, probably not a disparity. But if a village doesn't have water and a major metropolitan area does, then there's probably a disparity in there. So, there is some sense that there is a sense of unequal treatment with some injustices there. So, a healthcare disparity really simply is a difference in how populations receive care, whether it's by numbers or by treatments.

Bill Finerfrock: So, there are a lot of different things, I guess, then that could lead to disparities. Some could be geographic. It could be economic. It could be gender. It could be race. One of the things that we've been looking at with

Movement is Life is the way in which, how we pay physicians and how we pay hospitals can contribute to health disparities or help to address them. Can you talk to us about kind of your experience with and the correlation between how we pay physicians or hospitals and how that may contribute to either helping to address disparities or making them worse?

Dr. Parks: We're in a current climate of government fiscal responsibility, and there are so many, only so many dollars that can be attributed to healthcare. And so like everyone else, we're feeling the squeeze. With this squeeze in healthcare, there have been innovative healthcare models where you take large populations, maybe people undergoing in my field joint replacement, and you say, everyone's going to fit into a box. They're going to get a certain amount of care days in the hospital, a certain device, and the doctor, the hospital, and everyone's going to get one package number. Sounds pretty good, but unfortunately, populations are not that simple. There are large populations of people who are pretty sick. They suffer from what we call comorbidities or illnesses like diabetes, heart disease, and even social illnesses like depression. Maybe they don't have access to care like some of their counterparts. So, if we give them this sort of one box fits all, one reimbursement, and then the physician takes care of this person, maybe you don't have a house on Madison Avenue and a family to support you. Maybe you're going home by yourself and you're going home to an economically deprived area. So, some of these populations

are more likely to go to aftercare facilities like rehab facilities or nursing homes. All this costs money. So, this may provide a disincentive for physicians to take care of these patients and that's my fear. So, if a patient comes into the office and weighs a hundred pounds more than the next patient, it's likely that that patient may have some complications or may cost more to take care of. So, then when my report card goes public and I take care of lots of obese patients because I actually enjoy trying to make those people better, but when a report card on a provider who doesn't think about things like this goes public, then it may not be as good as the provider who selects sort of these ideal patients, sort of cherry-picking if you will.

Bill Finerfrock: Yeah, that's a term we've heard, cherry-picking. Some people refer to it as lemon dropping. You know the sad thing, and the ironic thing is what you're describing with regard to physician payments, we saw that same phenomenon occur when we changed how we paid hospitals, right. We went to a DRG, diagnosis-related group basis, which was kind of paying them on an average. And some hospitals did really well, but other hospitals that had populations and communities that were more challenging or had less volume suffered financially through no fault of their own or the quality of care they were providing and ended up closing their doors. So, Movement is Life has been working on something called the Equality in Medicare and Medicaid Treatment Act with Congressman John

Lewis from Georgia. Can you talk just a little bit about that? How familiar you are with that? And so, the bill would effectively say, we know that health disparities exist now, right? That some patients have disparate outcomes under our current payment model that some would say is colorblind. You know, that there's, you know, whatever code, whatever you're being paid, doesn't distinguish. If we go to a bundled payment or some type of value-based payment where this kind of averaging process can occur, you could get that outcome. So, what the Lewis Bill says is, okay, let's consider that in the design of the model. Let's build that in on the front end. Let's take that into consideration and not just simply say, okay, here's the payment. And tell us if you saved money and tell us if you had good or bad outcomes. It says, well, tell us who got care, right? Because one of the challenges is maybe some of those folks aren't going to get care.

Dr. Parks: So, one of the interesting studies that we've done at our institution on disparities, we looked at a large volume of thousands of patients that had already had surgery. We did something called geocoding and your zip code with that five-digit number that none of us ever remembers tells us a lot about you. Where you live because when the census takers come, they look at how many people are insured? What's the median income in your area? And one of the things that we looked at was the percent poverty by geocode. So, we took thousands of patients who had had surgery, and we

looked at their geocode, and then, we separated them by race. White patients, black patients, and we geocoded them. And we found that as poverty increased in their area where they lived, their outcomes were worse. Same patient, same hospital, same doctors. So, this is a reflection of the importance of why we should think about the Lewis Bill and the Equality in Medicare and Medicaid. And we should be careful as we go to new models of healthcare, to not disincentivize the care of certain groups of patients. And in order to provide quote-unquote, an extra consideration for those patients who may need it and to incentivize physicians to provide equitable care for all.

Bill Finerfrock: Yeah, there was just a study recently that was published, looking at hospital readmissions and in particular safety-net hospitals. One of the things they found was that the safety-net, hospitals were much more likely to be hit with readmission penalties, but the researchers went back and took into account all the various social geocoding, poverty, et cetera, and said that if the payment model had taken that into account, half of the hospitals that got hit with penalties wouldn't have had any penalties at all. The idea being that they were good institutions, but because the patient population they were caring for was more challenging, they didn't fare as well. Is that the kind of thing you're talking about?

Dr. Parks: Absolutely. So, we know not just in this new study, but there've been several past studies that show that certain racial and ethnic minority groups have higher rates of readmissions after joint replacement surgery or after surgery in general. So, I'm not sure of those factors that contribute to it on an individual level, but if you're taking care of those patients, then you're prone to penalties under new policies and new paradigms of payment. So, we need to take these concerns and consider them before we make those changes and what the unintended consequences will be on our patients.

Bill Finerfrock: Yeah, I think that's the unintended consequences. You know, one of the things that I learned many years ago when I started working in Washington is that we have sins of comission and sins of omission. And very often some of the worst outcomes occur because of a sin of omission. We didn't think about that when we adopted the policy. We didn't intend it to occur that way. So, then, we have to go back. I think the Lewis Bill really tries to say, you know what? We know how disparities exist now. Let's try to build this model in a way that makes sure that it doesn't make it worse and it potentially makes it better. You've traveled around the country. I mean, do you think this is isolated to urban areas? I know you grew up in South Carolina. Is this an urban phenomenon, or do you think it's something that cuts across geographic lines?

Dr. Parks: I think it's an American phenomenon that cuts across ethnicity and race. Poor people of all races are probably adversely affected. There may be differential effects by race. But whether you're poor and you grow up in the Appalachian in the South, or you grow up in the inner city, New York City, there are probably differences and adversities that you face in your recovery and risk factors that you bring with you. So large groups of poor patients have extremely high rates of obesity, diabetes. They don't have access to care. So, these same patients having surgery are more likely to have the adverse outcomes that we talked to that are going to trigger those penalties to hospitals and lesser payments to doctors.

Bill Finerfrock: So, you know, having been a surgeon, as long as you have, if you could say anything to policymakers in Washington, DC who are looking at these issues, what would your message to them be as someone who's on the front lines, who as you pointed out really likes the challenge of taking on patients, perhaps who are a little bit more difficult, more challenging to help them improve mobility, what message would you say to folks in Washington, DC, who are looking at these things?

Dr. Parks: I would say one size doesn't fit all, essentially. It's great that we have new payment models that we're trying to be financially responsible and that may work for a large majority of patients, but we have to consider that there are many patients in different circumstances, and we need to carve

out an understanding of how we provide care for those patients, particularly, as America becomes a more obese nation. Those patients are not the same as patients who have normal weight. They're more complicated. Not only are they more difficult to take care of, but they also have other concurrent medical issues, diabetes, hypertension, heart disease. So, we should think, great. It's wonderful. If all the patients fit into Box A and they're healthy and we have a new paradigm, diamond payment model. But we want to incentivize all health care providers to provide good care to all Americans and I think that we need to do this by thinking about those patients that don't fit into the normal box and how do we provide care for those patients?

Bill Finerfrock: Well, thank you, Dr. Parks. Appreciate the time you spent with us. And thank you everybody for listening to this podcast from Movement is Life.

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