Inflammatory Bowel Disease among Black American Population: Assessing Disparities and Determinants of Pharmacologic Management and Ambulatory Care

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Abstract

Literature review: no time, through Google Scholar & PubMed
Inclusion criteria: meta-analysis, systematic reviews, RCTs, observational, case-control studies, cohort, and cross-sectional studies about racial disparities of medical therapies and ambulatory care in the black population in America with IBD
Exclusion criteria: narrative reviews or editorials, and subpopulations, and like pregnant women.
Medical therapy: corticosteroids, 5-aminosalicylic acid (5-ASA) derivatives (mesalamine and sulfasalazine), immunosuppressants (azathioprine, methotrexate, mycophenolate, cyclosporine, tacrolimus, 6-mercaptopurine), and biologic agents [anti-TNF agents (infliximab, adalimumab, golimumab, and certolizumab), vedolizumab, natalizumab, ustekinumab, and tofacitinib].
Ambulatory care: any outpatient gastroenterology follow-up

Public Health Significance
- Black American IBD patients have lower disease burden than whites
- However, have twice the prevalence of IBD-related hospitalization and death compared to other ethnic groups
- Research inconsistent on whether disease behavior is more severe in this population
- Studies corroborate racial disparity in quality of life and management, both of which are worse for this population

Objectives
- Assess the public health significance of racial disparity among Black American IBD patients
- Identify predictive factors alongside race/ethnicity that impact these racial disparities
- Characterize disparities/determinants of health in access, utilization, and adherence to pharmacologic therapy
- Characterize potential disparities and determinants of health in access, utilization, and barriers to ambulatory care follow-up

Table 1: Disparities in Access and Utilization of Pharmacologic Management

<table>
<thead>
<tr>
<th>Studies Showing Racial Disparities</th>
<th>Studies Showing No Racial Disparities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six studies: white patients more likely to be treated w/ immunomodulators and infliximab, despite similar disease severity</td>
<td>Two studies: no disparity in biologic or immunomodulator therapy, after controlling insurance and SES</td>
</tr>
</tbody>
</table>

Table 2: Disparities in Adherence to Pharmacologic Management

<table>
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<tr>
<th>Studies Showing Racial Disparities</th>
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</thead>
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<tr>
<td>Two studies: one validated scale of adherence found 74% reduced odds being adherent AA vs. White</td>
<td>No studies, but also limited studies overall about racial disparities in IBD med adherence</td>
</tr>
<tr>
<td>Other study: AA more likely to discontinue, meds when felt better and less likely to feel disease under control</td>
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Table 3: Access and Utilization of IBD Ambulatory Care

<table>
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<tr>
<th>Studies Showing Racial Disparities</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Two studies: lower rate GI clinic use by AA</td>
<td>One study: no association</td>
</tr>
<tr>
<td>Two studies: higher IBD-related ED admission and inpatient hospitalization</td>
<td>One study: AA more likely to have highest annual vs/pt/person</td>
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<tr>
<td>One study: similar hospitalization across group, but different barriers to ambulatory care noted</td>
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</tr>
</tbody>
</table>

Cost of Healthcare
- More expensive
Transportation
- More difficulty obtaining referral to specialist & long wait times
Social support
- AA more likely to have any social support

Barriers to Ambulatory Care...

Discussion/Conclusion
- Racial disparities in IBD management is limited in this population
- Need to perform more research looking at effect of race and SES individually and together
- Acknowledge black diaspora in research, immigrant vs. US-born
- Need for patient education programs + behaviorally-oriented programs - perception/trust/beliefs that influence adherence and utilization of meds

References

Faculty Advisor
Dr. Denise Bruno, MD, MPH
Community Health Science