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Disparities in Osteoporosis Care: Addressing Screening and Treatment Barriers

Announcer:
You're listening to *On the Frontlines of Osteoporosis* on ReachMD. And now, here's your host, Dr. Jennifer Caudle.

Dr. Caudle:
Welcome to *On the Frontlines of Osteoporosis* on ReachMD. I'm your host, Dr. Jennifer Caudle. And joining me to examine racial disparities in osteoporosis management is Dr. Nicole Wright. She's an Associate Professor and the Director of Education for the Center of Health Outcomes, Implementation, and Community-Engaged Science, or CHOICES for short, at Tulane University School of Medicine. Dr. Wright, thank you so much for being here today.

Dr. Wright:
Thank you so much for having me and talking about a very passionate topic of mine.

Dr. Caudle:
So let's just dive right in, Dr. Wright. What differences in bone mineral density do we see in various racial and ethnic groups?

Dr. Wright:
When you look at studies—so, for example, the National Health and Nutrition Examination Survey, which is a nationwide survey of adults in the U.S.—when they look at bone mineral density, you typically see that in Hispanic populations, you may see equal or comparable bone mineral density at the hip site, so the femoral neck site, but Hispanic populations tend to have lower bone mineral density at the lumbar spine, whereas Blacks tend to have higher BMD at both sites, and Asians tend to have lower BMD at both sites.

Dr. Caudle:
And can you describe some of the barriers that patients from diverse racial and ethnic backgrounds face in accessing osteoporosis screening and treatment?

Dr. Wright:
Barriers to healthcare access are no different for osteoporosis than they are for any other condition. So lack of transportation and other sort of economic barriers could be hindering someone to get screened for osteoporosis and/or get treated for osteoporosis.

To me, the biggest barrier is more around knowledge, and I think from both the provider standpoint as well as the patient standpoint, there's just a low knowledge about osteoporosis and bone health in general in non-Hispanic Black and Hispanic populations compared to Asian or non-Hispanic White populations. And so because of that lack of knowledge, it doesn't rise to the importance of say, "Oh, your doctor ordered a DEXA scan," and you're like, "What's that?" "Something for bones." I don't need to worry about my bones." And "I have to go to another visit," or "It's at a different place." And so that may be part of the reason why we're seeing lower screening rates in primarily non-Hispanic Black populations.

And then the same thing with respect for provider knowledge, even though there are guidelines saying every woman 65+ should have a DEXA scan, providers are like, "Oh, I'm seeing a Black patient. They don't have to worry about their bones now; we have all these other preventative measures we need to do. We'll postpone DEXA for a later time." And typically, that may not happen based on the data that we're seeing out there.

Dr. Caudle:
And if we shift our focus to fractures for just a moment, how do those rates differ across racial and ethnic groups?

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Dr. Wright:
Yeah. So like with BMD, you're thinking, "Okay, if Blacks have higher BMD, they must have a lower fracture rate," and that's pretty true with respect to hip fractures. Asians have lower BMD, so should we expect them to have a higher fracture rate? With hip fracture, that's actually not the case. Asians actually have a very low hip fracture rate, and so it's kind of this mix of, "Is BMD kind of driving that fracture difference that we see, or are there other factors at play that are related to racial and ethnic differences in fractures?" And again, what's most studied is hip fracture, so we have a lot of data on that. But in terms of incidence rates around fractures, we actually don't have a lot of really good data on those other fracture types.

Dr. Caudle:
For those of you who are just tuning in, you're listening to *On the Frontlines of Osteoporosis* on ReachMD. I'm your host, Dr. Jennifer Caudle, and I'm speaking with Dr. Nicole Wright about racial disparities in osteoporosis care.

So, Dr. Wright, now that we have a better understanding of the various disparities patients face, let's discuss strategies to address each of them, starting with screening and treatment access. How can we combat this common barrier?

Dr. Wright:
I think we can combat it from a couple of different angles. One is more of a systems-level kind of intervention, if you will—in whatever healthcare system you're in and whoever your insurance provider is—of saying, "When you turn 65, there should be an automatic order of a DEXA." So maybe that will get at some of the disparities that we see for low screening if it's driven by more of a provider lack of knowledge or a provider barrier. That still doesn't quite help if the patients don't recognize the importance of getting that DEXA scan and then going to actually get it. What I've been trying to do is to increase knowledge and awareness of osteoporosis in various communities of color— for me, primarily the Black community—so that when you get that order for the DEXA scan, you know it's an important piece; you know it's a part of your preventive services. Just like your mammogram, just like your colonoscopy, we have to do that bone test and get it done.

Dr. Caudle:
And considering that certain racial and ethnic groups are at greater risk of fractures, what strategies can we implement to prevent fragility fractures in these patient populations?

Dr. Wright:
You know, we want to prevent fractures in all populations, right? So we want to get everyone screened. If you have osteoporosis or if you have risk factors that put you at greater risk for fractures, we want to manage that with pharmacologic treatment, if necessary, and with other nonpharmacologic treatments like calcium, vitamin D, exercise, and nutrition.

Based on the literature, if we're trying to reduce hip fractures and the incidence shows that White women have the highest incidence of hip fractures, then what could we do in that population to reduce hip fractures? I don't really see much more than educating and providing that epidemiologic data of saying, "Here's where we are. Here's what we see. We want to reduce this. Here are ways to reduce fractures." How you say that to a White population could be very different than maybe how you approach that in a Hispanic population, in an Asian population, and in a Black population.

Dr. Caudle:
Given all the disparities that we discussed, how can we improve patient education around osteoporosis to ensure that women, particularly from underserved communities, really have a clear understanding of the condition and its risks?

Dr. Wright:
We can tackle this on multiple fronts. I am on the Board of Trustees of the Bone Health & Osteoporosis Foundation, and that organization has a lot of programming for patients around various elements related to bone health. But obviously, there are only so many people who interact with the BHOF website. So how do we get people who aren't interacting with those websites? I know there's a lot of community programs, particularly through Centers on Aging, that may have osteoporosis education classes, and so go to these groups and say, "Hey, let's talk specifically around racial and ethnic differences so that we can increase knowledge around bone health in some of your underserved populations."

We also can't forget about provider education. I've heard from providers that educational interventions don't work, but every time I've given a talk about disparities in osteoporosis, people are like, "I have never heard this before, so thank you for sharing it." And then I think one of the things that we need to do in bone health is to get with other providers and say, "Let me tell you about the link between" fill in the blank "and bone health." So let me tell you about the link between cardiovascular disease and bone health and why cardiologists should be thinking about the bone health of their patients. They aren't comfortable treating that but referring to the appropriate person. Let me talk to the oncologist. Let me talk to the endocrinologist who takes care of diabetes. Let me talk to those

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pulmonologists who are doing COPD so that "Hey, do you recognize that some of the medications that you're using in these conditions are bad for bone?" or "The pathophysiology of the condition is leading to increases in bone breakdown or decreases in bone formation." And so you, as a provider, being knowledgeable of that, talking to your patient about it, and then referring them to that appropriate person to take care of their bone health.

Dr. Caudle:
Now, unfortunately, we're almost out of time for today, but before we close, Dr. Wright, let's take a moment to look ahead. What future research areas do you believe are essential for understanding osteoporosis in minority populations? And how can healthcare providers advocate for this research?

Dr. Wright:
I think one thing we need to start with is, "Where are we?" I'm an epidemiologist, so I love the numbers, but maybe some people don't see the benefit of sort of descriptive epidemiologic research, but we need to know where we are. So continuing to evaluate incidence rates of various fracture types by race and ethnicity and not just focusing on hip fractures, looking into screening and treatment rates, and just showing where we are as a country, where we are as a region, where you are in your health system, etc. But then that's not enough. We then need to move the research forward. What can we do to mitigate some of these disparities that we are seeing?

Dr. Caudle:
And as those comments bring us to the end of today's program, I'd like to thank my guest, Dr. Nicole Wright, for joining me to examine racial disparities in the treatment of osteoporosis. Dr. Wright, it was great speaking with you today.

Dr. Wright:
Thank you so much for having me.

Announcer:
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