Data Driven Action: Pathways to Health Equity
## Agenda

<table>
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<th>Time</th>
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<tr>
<td>12:00-12:15</td>
<td><strong>Introductory Remarks by Jean Moody Williams, Director, Quality Improvement Group</strong></td>
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<td>12:15-1:00</td>
<td><strong>Less Talk More Action: Accelerating Innovative Strategies to Engage Racial and Ethnic Minority Communities in Health Care</strong> by Dr. Stephen Thomas, Director, Maryland Center for Health Equity, University of Maryland, College Park</td>
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<td>1:00-2:00</td>
<td><strong>Community Engagement: QIO Perspective Panel</strong> Participating QIOs: Alaska, California, Hawaii, Illinois, Texas</td>
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<td>2:00-2:15</td>
<td><strong>Break</strong></td>
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<td>2:15-3:00</td>
<td><strong>Why Race and Ethnicity Data Matter in Understanding Health Disparities</strong> by Dr. Darrell Hudson, Assistant Professor, Brown School of Social Work and Faculty Scholar, the Institute of Public Health at Washington University in St. Louis</td>
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<td>3:00-4:00</td>
<td><strong>Data and Health Equity: QIO Perspective Panel</strong> Participating QIOs: Arkansas, Kansas, New Mexico, Virginia</td>
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<td>4:00-4:30</td>
<td><strong>Closing Remarks: Disparity Lessons from Great Recession on Health Care Costs</strong> by Dr. Stephen Thomas and Dr. Je Chen, Assistant Professor, Health Services Administration, University of Maryland, College Park</td>
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WWW.CMSPULSE.ORG
WELCOME TO THE VIRTUAL CONFERENCE!

JEAN D. MOODY-WILLIAMS, RN, MPP
Director, Quality Improvement Group
Center for Clinical Standards and Quality Centers for Medicare & Medicaid Services

THE MEDICARE CLIMATE

GENDER

- 55% MALE
- 45% FEMALE

RACE/ETHNICITY

- 77% WHITE
- 5% BLACK
- 8% HISPANIC
- 10% OTHER

Department of National Coordinating Center
University of Maryland
School of Public Health
www.healthequity.umd.edu
Racial Trends in Medicare Enrollment
2004-2012

White

Black/ African American

All other Racial Groups (Excluding Black and White)

Asian

Hispanic

N. American Native

Racial Trends in Medicare Enrollment
2004-2012
5 MOST COMMON CHRONIC CONDITIONS

1. HYPERTENSION
2. HIGH CHOLESTEROL
3. ISCHEMIC HEART DISEASE
4. ARTHRITIS
5. DIABETES

THERE IS A SIGNIFICANT PROPORTION OF MINORITY MEDICARE BENEFICIARIES

THERE ARE SIGNIFICANT ECONOMIC DIFFERENCES BETWEEN WHITE AND MINORITY MEDICARE BENEFICIARIES

THERE ARE SIGNIFICANT DIFFERENCES IN HEALTH BEHAVIOR

THERE ARE SIGNIFICANT DIFFERENCES BETWEEN HEALTH MORBIDITY OUTCOMES
Less Talk More Action: Accelerating Innovation Strategies to Engage Racial and Ethnic Minority Communities in Health Care

STEPHEN B. THOMAS, PhD
FOUNDING DIRECTOR OF THE MARYLAND CENTER FOR HEALTH EQUITY
PROFESSOR OF HEALTH SERVICES ADMINISTRATION IN THE SCHOOL OF PUBLIC HEALTH

DNCC
Departures National Coordinating Center

CENTER FOR HEALTH EQUITY
MARYLAND SCHOOL OF PUBLIC HEALTH
www.healthequity.umd.edu
Less Talk More Action: Accelerating Innovative Strategies to Engage Racial and Ethnic Minority Communities in Health Care

Architects of Community Engaged Research

Drs. Craig S. Fryer, Mary A. Garza, Stephen B. Thomas, Sandra C. Quinn and James Butler, III
COE Goals:

1. To establish and sustain a community engaged research enterprise on critical health disparities;

2. To raise the visibility of racial and ethnic health disparities and promising solutions with Marylanders; and

3. To facilitate action for change in the structural determinants of health in Maryland.
THE OPPORTUNITY

Photo Credit: Sandra Quinn

AFFORDABLE CARE ACT of 2010
Maryland Health Improvement & Disparities Reduction Act of 2012

Signed into Law by Governor Martin O'Malley on April 10, 2012.

THE CHALLENGE

Photo Credit: Sandra Quinn
ATTRIBUTES OF RESEARCHERS AND THEIR STRATEGIES TO RECRUIT MINORITY POPULATIONS: RESULTS OF A NATIONAL SURVEY

Sandra Crouse Quinn*, James Butler III*, Craig S. Fryer*, Mary A. Garza*, Kevin H. Kim*, Christopher Ryan*, Stephen B. Thomas*

Maryland Study Finds Use of Different Recruitment Strategies Defines Health Researchers: Maryland Study Examines Researchers by Strategies for Minority Recruitment ...read more »
"...The people who ran the study at Tuskegee diminished the stature of man by abandoning the most basic ethical precepts. They forgot their pledge to heal and repair. They had the power to heal the survivors and all the others and they did not. Today, all we can do is apologize."

President William Jefferson Clinton
The White House
May 16, 1997

http://www.cdc.gov/tuskegee/clintonp.htm

THE FRAMEWORK

Photo Credit: Sandra Quinn
Toward a Fourth Generation of Disparities Research to Achieve Health Equity

Stephen B. Thomas,1,2 Sandra Crouse Quinn,1,3 James Butler,1,4 Craig S. Fryer,1,4 and Mary A. Garza1,4

1Center for Health Equity, 2Department of Health Services Administration, 3Department of Family Science, 4Department of Behavioral and Community Health, School of Public Health, University of Maryland, College Park, Maryland 20742-2611; email: sbt@umd.edu, scquinn@umd.edu, jbutler9@umd.edu, csfryer@umd.edu, magarza@umd.edu

Key Foundations

1. Utilizing public health critical race praxis (PHCR) as our conceptual framework,
2. Addressing structural determinants of health through comprehensive multilevel interventions,
3. Utilizing comprehensive evaluation, and
4. Necessitating explicit attention to self-reflection by the researcher.
Cultural Confidence

“...a lifelong process based on the individual’s self-reflection about their personal biases and prejudices. We define a culturally confident person as someone who is flexible and humble enough to admit ignorance and is willing to be uncomfortable addressing complex racialized issues.”

INNOVATIVE ACTION

Photo Credit: Sandra Quinn

2001 FEDERAL DHHS

TAKE A LOVED ONE TO THE DOCTOR DAY
THE HEALTHY BLACK FAMILY PROJECT
(2004-2012)

Get Your Health Education Check-Up at

Next Level Barber Shop
5910 Riggs Road
Hyattsville, MD 20783

Did you know: High blood pressure often has no warning signs or symptoms. Once it occurs, it usually lasts a lifetime. If uncontrolled, it can lead to heart and kidney disease, stroke, and blindness. (Guide to Lowering Blood Pressure with DASH Eating Plan, National Institutes of Health, National Heart, Lung and Blood Institute) Come learn what you can do.
DANGER AND OPPORTUNITY

Photo Credit: Sandra Quinn
The danger is to assume that:

1. **racism** is *not* relevant in the scientific pursuit of solutions for the elimination of health disparities;

2. that some populations will always suffer premature illness and death by virtue of their **culture bound lifestyle choices**; and thus,

3. that the elimination of disparities is impossible and health equity **unachievable** in a free market society

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The opportunity is to recognize health disparities as an issue of justice because specific groups were subjected to systematic racial discrimination and denied the basic benefits of society, a violation of the social contract.

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ACHIEVING HEALTH EQUITY

“...we can no longer be victims of inaction. Our role as scientists is to provide the knowledge and perspectives for effective practice and policies... We have a moral obligation in our society to do what is necessary to improve health, and the **health disparities research community should be in the vanguard of that movement**” (Ruffin, 2010, p. 59).


Acknowledgement & Disclaimer

- The projects described are supported by Award Numbers 7RC2MD004766 and PG60MD000207 from the **National Institute on Minority Health And Health Disparities (NIMHD)**.

- The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIMHD or the National Institutes of Health.
THANK YOU VERY MUCH!

Stephen B. Thomas, PhD.
Professor, Department of Health Services Administration
Director, Maryland Center for Health Equity
School of Public Health
The University of Maryland
sbt@umd.edu
www.healthequity.umd.edu
www.twitter.com/umdhealthequity
COMMUNITY ENGAGEMENT: QIO PANEL

ALASKA

HAWAII

CALIFORNIA

ILLINOIS

ALASKA

MOUNTAIN PACIFIC QUALITY HEALTH
Medical Respite Care for the Homeless

• National Background
• Identify Problem
• Anchorage Pilot

David Sohmer MPH CPH
Mountain-Pacific Quality Health-Alaska
October 1, 2013

What is medical respite care?

• Acute and post acute medical care for homeless
• Too ill or too frail to recover from a hospital stay on the streets
• Not ill enough to remain in the hospital

Source: NHCHC Directory 2013
What is medical respite care?

• Medical needs: Visiting nurse, public clinic
• A place to recuperate. Safe, dry, clean
• Meal on Wheels
• Case management: connect to resources

Source: NHCHC Directory 2013

National picture

• First program 1985: Washington, DC
• 62 programs in 26 States
• Length of stay: avg. 35 days, med. 25 days
• Funding sources: hospitals; HRSA; HUD; Medicaid; Medicare; private; local governments; religious orgs.; foundations; United Way; others

Source: NHCHC Directory 2013
Programs Established in US by Year

Characteristics of medical respite care

- Short term program for homeless
- Residential care: opportunity to rest while recuperating and accessing appointments
- Whole person care: food, home health, medical appointments
- Low cost, high quality, everyone saves $
- *Homeless shelter or the street are not appropriate venues to recover from hospital stay*

Source: NHCHC Fact Sheet 2012
Characteristics of medical respite care

• Type of facilities in U.S.
  – Homeless shelter - 24
  – Stand-alone facility - 16
  – Transitional housing - 8
  – Assisted living facility / nursing home - 7
  – Apartments / motel rooms - 5
  – Substance use treatment facility - 1

Source: NHCHC Directory, 2013

Identifying problem

• Sept. 2011 - Anchorage coalition convenes: CCTP-3026 application
• Faction advocates homeless/mentally ill
  – Small proportion Medicare beneficiaries
  – Vulnerable
  – High utilizers emergency department
  – High readmissions?
Identifying problem

• Oct. 2012 – Patient safety conference
  – Affinity Learning and Action Network
  – Break out session: Care transitions for homeless and people living with mental illness
  – Room filled + >60 on telephone
  – Juneau pilot program described by caller

Organize project

• April 2013 Juneau site visit
• June convened steering group
  – Emergency shelter
  – Public medical clinic
  – Community advocate
  – Academic - Social Work prof, RN grad student
  – Municipality of Anchorage
  – Planner Juneau program
  – QIO
• Small = efficient
Organizing the project

- Areas exploring
  - Venue model: Hotel/shelter/free standing
  - Medical services: Home health/clinic appointments
  - Meals on Wheels
  - Case management
  - Needs assessment
  - Funding

Impact on organization

- Anchorage Care Transition Network
  - Meets real community needs
    - Saves money
    - Frees hospital beds
    - Improves quality of care
    - Win – Win – Win
  - Sustainability: Energy and engagement
Impact on organization
QIO: Opportunity Creates Transformational Change

LAN philosophy
- Action-oriented
- Patient-centered
- Community organizing
- Knit together healthcare silos
- Values: shared interests, sense of community
- Decrease health care costs
- Mentored by experts
- Organic
Community Building to Close Health Disparities

Shanti Wilson, MBA, PMP, HIT Director
Health Services Advisory Group of California, Inc.
(HSAG of California)
Enlist Trusted Community Groups

Choose Trusted Social Hubs
Select Convenient Logistics

Involve Knowledgeable Partners
Envision Continuity

Case Study 1: Fruitridge Community Meetings

Josie
“These meetings keep me on track.”

Linda
“Are you coming back? Love the information!”
Case Study 1 Outcomes

* different denominator, but large overlap in population

Case Study 2: Barbershop Health Outreach Project
Case Study 2 Outcomes

39 screened
Normal BP = 31%
Pre-Hypertensive = 44%
Hypertensive, Stage 1 = 15%
Hypertensive, Stage 2 = 10%

Opportunities
How did you know there was a problem to be addressed?

- **Healthcare Data**
  - 68.9% of Waimanalo residents identify as Native Hawaiian or Other Pacific Islander (U.S. Census Bureau, 2010).
  - 32.6% of the population is considered obese.
  - 13.58% of the population has or has had diabetes.
  - 24.83% reported having no leisure time for exercise or physical activity during the past 30 days.
  - Native Hawaiians have the highest coronary heart disease mortality rates in Hawaii.

- **Not familiar with their roles**
  - Doctor is seen as the authority figure who is not to be questioned and whose time is not to be wasted.
Beneficiary Awareness

- Health care messages are not being received.
- Most messages are presented from the provider’s perspective.
- The beneficiary’s role in self managed and quality, cost effective health care needs to be clarified and understood.
  - Prevention from the patient perspective is necessary, vital
    - Education and activity for prevention are needed.
    - Beneficiaries need and want health tools and tips that they understand.
    - Part of the solution must include training on self-managed care.

- The jury is out on prevention from a payer perspective.

Indifference and lack of participation has been a barrier

Waimanalo community members have suggested ideas that might work to promote participation and commitment from Waimanalo residents:

- Listen to the community; don’t just preach.
- Stay awhile. Invest more time in the community.
- Be culturally sensitive.
- Use words and phrases easily understood by the community.
- Blend in.
How did you organize yourselves to come up with a solution?

QIO partnered with FQHC

- Interested in piloting a Therapeutic Lifestyle Change program designed BY the Waimanalo community.
- Organized the 10th SoW CVH LAN around building a lifestyle change program.
- Stakeholders and community partners were recruited.
- Beneficiaries served as an affinity group.

Therapeutic Lifestyle Change

Create a Therapeutic Lifestyle Change program that uses rapid cycle development to test interventions, educational content, and how material is presented and delivered to the beneficiary audience.
Goal of LAN was to create a Prevention Intervention from the ground up that would be piloted in Waimanalo and become a model for the Native Hawaiian population in the State

Simple objectives of the Learning and Action Network:

Encourage beneficiaries to

**Learn**
- about the latest health information and resources and how to access them
- to self-manage their health
- about the triggers of unhealthy routines

**Take Action**
- move more
- eat better
- adhere to their medications
- regularly measure their blood pressure, pulse, weight, waist circumference, and number of steps taken
- document their habits and routines

To achieve these objectives, a 12-week Learning and Action program was developed.
Learning

- Basic health information was derived from Million Hearts ABCS, AHA, CDC, CMS, ADA.
- Each message was presented in ways that were more easily understood by beneficiaries.
- Instructional design, delivery, and presentation were all reviewed by the LAN.
- A framework for habit change was introduced as described in the best-selling book, The Power of Habit by Charles Duhigg.
- Health topics were discussed in a classroom setting.
- Diabetes educators, pharmacist, behavioral therapist, nutritionist, and nurses shared information.

Action

- Exercises and stretches focusing on falls prevention.
- Dancing (elements from the hula incorporated into the electric slide).
- Exergaming (Virtual bowling using Microsoft Kinect on X-box).
How did Play 4 Prevention impact your organization?

Cross AIMs work flourished. C9 partnered with:

- C8 Care transitions and the windward community that provided services to Waimanalo.
- C 7.3 Medication adherence and reconciliation. QIO pharmacist worked with everyone in the program.
- C 7.1 to incorporate falls prevention stretching, exercises, and dancing.
- C 10 Crisp and success stories

If you were to do it all over again, what would you do differently?

There are no regrets, just opportunities to improve. The more we learn the clearer our objectives become. The following are added to our wish list:

- Incentivize the beneficiary.
- Involve the beneficiaries in all aspects of their healthcare.
- Create the foundation for a wellness community.
- Discover methods for introducing self-managed data into the workflow of the patient/provider office visits.
Stakeholders and Technology

• Work with payers and community centers to align P4P program educational content with provider earned incentives.
• Discover methods for funding prevention interventions by working directly with payers.
• Introduce concept of automated hovering.
• 7-inch Tablet technology can be used for tracking individual health data (apps), passive data collection, healthcare hovering by the P4P program and learning to use the tablet as a research tool to explore cost effective and quality health care options.

Beneficiaries go from feeling like they are part of the problem...
...to realizing they are a solution.
Community Engagement: Quality Improvement Organization
Perspective Panel – Illinois

- Community Care Transitions and Adverse Drug Events helped lay the foundation for community-based approaches
- Hiring staff with community development, organizing, health and outreach experience
- Analyzing information from Medicare databases and information from the National Coordinating Centers (NCC)
  - Patient Origin and Provider Setting
- Results from Care Transitions NCC November 2012 Report
  - Startling
Startling Data – 2011 Medicare Fee-for-Service Claims

Figure 1.1: Admissions and Readmissions by Demographic Characteristics

National

Figure 2.1: Admissions and Readmissions by Demographic Characteristics

Illinois
Focused Initiatives on Disparities

- Geographical variation
- Financial resources – income and savings
- Literacy and health literacy
- Race and ethnicity
- Incidence of Violence

Initiated Work with Community and Faith Based Organizations

- Identification of high incidence of cardiac disease and gaps in preventive services
  - Cardiac collaborative initiative with dozens of organizations serving communities outside of the Chicago metro area
- Targeted Flu Immunization Campaign focused on nursing homes with low rates of flu immunization
  - Presentations by Nursing Homes with 5 Star, 100% Flu Immunization Rates for Short and Long Stay Residents
  - Directly communicating the importance of flu immunization and 2012-2013 performance to nursing home administrators
  - Putting a state spotlight on Nursing Home and Home Health Compare Flu immunization rates
First Ladies Health Initiative

- Over 45 Chicago area churches hosted health events on September 22, 2013
- Initiative grows each year in terms of church involvement, attendees and participating health organizations
- Growing partnerships and network through First Ladies

Special Innovation Project

- Reducing hospital avoidable admissions and avoidable readmissions through preventive services in Black and Hispanic populations
  - Identify and work with community-based and faith-based organizations to identify senior communities
  - Engage seniors in Senior Connection Advisory Groups to identify perceived barriers to Medicare prevention services and ways to overcome barriers
  - Develop culturally sensitive materials that can be distributed as a result of relationships with community-based and faith-based groups
  - Utilize radio health talk shows in Black and Hispanic communities
Special Innovation Project – Targeted Communities

- Key Criteria for Communities Selected in Chicago:
  - Sizable senior population
  - Active community and faith-based organizations
  - Low income and low savings
  - High incidence of violence
    - Englewood
    - Washington Heights
    - Lawndale
    - Little Village

1,653 Shootings
In Chicago in 2013 as of September 25 at Noon
• Pat Merryweather
  – Executive Director
  – pmerryweather@ilqio.sdps.org
  – 630-928-5860

• Michael Townsend
  – Quality Improvement Facilitator
  – mtownsend@ilqio.sdps.org
  – 630-928-5816

• Vadie Reese
  – Senior Quality Improvement Facilitator
  – vreese@ilqio.sdps.org
  – 630-928-5857

Questions?
Comments?
Reactions?
BREAK TIME

THE SECOND HALF OF THE CONFERENCE WILL RESUME IN 15 MINUTES

Why Race and Ethnicity Data Matter in Understanding Health Disparities

DARRELL HUDSON, PhD
ASSISTANT PROFESSOR, BROWN SCHOOL OF SOCIAL WORK
FACULTY SCHOLAR, INSTITUTE OF PUBLIC HEALTH AT WASHINGTON UNIVERSITY
Why Race and Ethnicity Data Matter in Understanding Health Disparities

Darrell L. Hudson, PhD MPH
Assistant Professor

Health Disparities: Civil Rights in the 21st Century

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane”

Martin Luther King
According to Healthy People 2020

“A health disparity is a particular type of health difference that is closely linked to ...people who have experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, mental health, **cognitive**, **sensory**, or physical disability, sexual orientation, **geography**, or other **characteristics historically linked to discrimination or exclusion**. “

http://www.healthypeople.gov/2020/about/disparitiesAbout.aspx
Institute of Medicine Definition of Health Disparities
Differences, Disparities, and Discrimination:

AIDS Cases Among Adults and Adolescents by Race/Ethnicity
What explains disparities?

Social Determinants

• Race
• Socioeconomic position
• Social context
• Social determinants are the least well understood but potentially the most significant factors
Race Matters

1. Racial classification depends on the local criteria for categorizing people
2. Folk Taxonomy
3. Can be a member of one race in one culture and another race in a different culture
4. Racial classification is not stable
5. Racial classification is not permanent (born white but die black)

Types of Racism

1. Individually (personally) mediated
2. Institutionalized
3. Internalized

# Social and Economic Inequality

### Median Net Worth of Households, 2005 and 2009

*in 2009 dollars*

<table>
<thead>
<tr>
<th>Year</th>
<th>Race</th>
<th>Net Worth</th>
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<tbody>
<tr>
<td>2009</td>
<td>Whites</td>
<td>$113,149</td>
</tr>
<tr>
<td></td>
<td>Hispanics</td>
<td>$6,325</td>
</tr>
<tr>
<td></td>
<td>Blacks</td>
<td>$5,677</td>
</tr>
<tr>
<td>2005</td>
<td>Whites</td>
<td>$134,992</td>
</tr>
<tr>
<td></td>
<td>Hispanics</td>
<td>$18,359</td>
</tr>
<tr>
<td></td>
<td>Blacks</td>
<td>$12,124</td>
</tr>
</tbody>
</table>

*Source: Pew Research Center tabulations of Survey of Income and Program Participation data*

**PEW RESEARCH CENTER**
Social Context

1. How does it shape norms?
2. How does it enforce patterns of social control?
3. How are opportunities to engage in certain behaviors reinforced, truncated or absent?
4. How does social context produce stress?

Racial Residential Segregation

How Data Can Drive Action
Reduce Hospital Readmissions

• Congress identified reductions in hospital readmissions as an approach to reduce Medicare spending

• Many at highest risk of readmissions have Type 2 diabetes along with another diagnosis.

Example of Data Driven Action

- Develop a community based program to address diabetes self-management among seniors living in high-risk zip codes in the metropolitan St. Louis area

- Reduce unscheduled hospital readmissions by supplementing the Stay Healthy Outreach Program
Example: Data Driven Action

■ For The Sake of All Program

1. A multi-disciplinary study on the health and well-being of African Americans in St. Louis
2. Designed to provide evidence of the impact of persistent disparities on all members of the region regardless of race or socioeconomic status
3. Designed to present the regional economic and health consequences of intervening (or failing to intervene) on social determinants of health

Program Website: http://forthesakeofall.org/

Big Data:
Selected National Data Sets to Guide Action
National Data Sources

AHRQ Medical Expenditure Survey

Most complete source of data on the cost and use of health care and health insurance coverage

National Health Interview Survey

Used by DHHS for tracking illness and disability trends

Behavioral Risk Factor Surveillance System

Collects information on cigarette smoking, alcohol use, physical activity, diet, hypertension, and seatbelt use.
Other Data Sources

The Dartmouth Atlas of Health Care
www.dartmouthatlas.org includes Medicare reimbursements per enrollee

THANK YOU VERY MUCH
DATA PANEL

ARKANSAS

KANSAS

NEW MEXICO

VIRGINIA

ARKANSAS

ARKANSAS FOUNDATION FOR MEDICAL CARE
Collecting Race/Ethnicity Data
Collecting Race/Ethnicity Data

• Developed tool as part of 8th SOW
  • Facts on why to collect demographic data
  • How to decrease barriers to data collection
  • Legal justification for collection
  • Helpful resources

• Working to stratify at-risk population with diabetes
  • Known racial/ethnic group differences in diabetes prevalence
  • Assisted provider staff with data capture and reporting

How to Access Data

• **Assistance and Training**
  • Collaborative offers support in setting up stand-alone registries
  • Manual collection with spreadsheets if EHR was not option

• **EHR**
  • Pulling reports through EHR registries and reports
  • Checking for missing demographic data in appropriate fields
Successes and Challenges

- **Challenges**
  - Overcoming reservation to acquire self-reported data
  - Lack of standard policy to collect and analyze data within clinic
  - Small numbers per measure per race/ethnic group for very small/rural clinics (n=2)

- **Successes**
  - Including recorded demographics and cultural competency training in overall staff evaluation
  - Educational intervention to help staff understand need to collect and analyze data

Data Example

- **Rural clinic**
- **One provider**
- **10-15 patients per day**
- **Million Hearts partner**
Advice for Race/Ethnicity Data Collection

- Continue to encourage clinics to capture demographics and run stratified reports

- Relay to EHR vendors the need for easier stratification of data and standard menu reports by race/ethnicity
Kansas
Sarah Irsik-Good, MHA
Director of Quality Improvement

Kansas’ Disparity Journey

➢ No true Contractual Obligation

The QIO will report data to the National Coordinating Center quarterly. The QIO must always explore methods of identifying populations that are dually eligible for Medicare and Medicaid and vulnerable populations that may receive disparate care.

2. Cultivating Leaders in the Local Area
   a. The QIO shall convene health care leaders (including providers, administrators, boards of directors and patients) around an actionable agenda that promotes specified CMS Aim(s) as described throughout this SOW. This will also include identifying the high performing organizations for leaders to form affinity groups as needed to enhance opportunities for learning, or problem solve around important topics that are applicable to the state or issue such as persons that have dual eligibility, rural concerns, and any populations where disparate care may be occurring.
Kansas’ Disparity Journey

- Always been somewhat cognizant of impact of our QIO work on disparities in Kansas

- Doing just enough to answer “yes” on our site visit grid

- Minimally Competent!

Disparities National Coordinating Center (DNCC)

- DNCC as a resource
  - Webinars
  - COP Calls

- DNCC data reports
  - What to do with them?
Special Innovations Project

- PFEC Campaign project aimed at disparities in Southeast Kansas (Disparities in access to primary care providers)

- Looking at specific staff to manage SIP project, staff with communications and outreach background

- Disparities were under-addressed

Where do you start?
Disparities Team

- Disparities Team – Project Manager; Project Specialist; Communications Liaison

- Provides cross-theme attention to disparities in Kansas

- Using lessons learned, barriers, successes across 10SOW aims

Utilizing Data

- Disparities team acts as the Gate Keeper for data

- Present data (our own analyst created reports, DNCC reports, etc.) at project team meetings with suggestions for awareness, education or technical assistance to providers, beneficiaries, etc.

- This is really just starting to take shape, but very excited about where we are going!
Advice

- Don’t let disparities be one person’s job!

- Don’t let disparities be a back-burner responsibility!

- Be creative! Create awareness of the good, the bad, the ugly!
Standardizing Race, Ethnicity, Language and Tribal Affiliation Data: the New Mexico Experience

Margy Wienbar, MS
and Elayne Villa

HealthInsight New Mexico

Background for the New Mexico Project

• State Reporting Requirements
  – Hospitals to collect and report race, ethnicity and tribal affiliation data
  – Goal: demonstrate improvement in health care disparities through performance measures
  – Stratify performance data by race, ethnicity and tribal affiliation

• Robert Wood Johnson Aligning Forces for Quality
  – Health Research and Educational Trust (HRET)
  – www.hretdisparities.org/
  – George Washington University
Importance of REAL(T) Data Collection

Although the collection of race, ethnicity and language data does not necessarily result in actions that will reduce disparities and improve care, the absence of the data guarantees that none of that will occur.


Process to Ensure Successful Data Collection

Figure 1: Four-Step Approach to Ensure Successful REAL Data Collection

New Mexico’s Population

Population by Race/Ethnicity New Mexico and U.S., 2010

New Mexico Tribal Lands: 22 Tribes

New Mexico Tribal Lands

Tribal Lands

Hospital

358 miles

10/1/2013
Three Phases

• Pilot phase 2011
  – 9 hospitals, observations, training
• Full rollout 2012
  – 39 hospitals, onsite training
• Follow-up 2013
  – Phone calls and follow-up visits to assess implementation

Standardize Approach

• Collect data at registration
• Order of questions
  – Ethnicity first
• Self-identification
• Confidentiality
• Staff education
  – Role play; modeling (scripts)
  – Gave front line staff an understanding of why this is important (rationale)
What New Mexico Learned

• Electronic systems that cannot configure categories, especially tribal affiliation
• Importance of seeing processes and screens
• Showing people their options helps – streamlines
• Needs to fit into flow of registration process
• Staff confidence/comfort
  – Importance of “WHY” for both staff and patients
• Staff turnover
• Confusion of race vs. ethnicity

Outcomes—Hospital Inpatient Discharge Data (HIDD) Collection

• NMDOH built quality checks
  – Race/ethnicity fields left blank > 5%= error
  – Native American race without tribal affiliation noted > 5% = error
  – Thresholds exceeded, requires resubmission of data
• Data completeness has increased 2011-12
  – Race entry: 84.5 to 93.5 percent
  – Ethnicity entry: 88.3 to 93.2 percent
  – Reported AIAN, with tribal affiliation: 82.3 to 90.2 percent
Acknowledgements
Nicole Katz, Epidemiology and Response Division, New Mexico Department of Health
Patricia Montoya and Elayne Villa, HealthInsight New Mexico
George Washington University

Questions?

For More Information
Margy Wienbar
Director of Operations
HealthInsight New Mexico
mwienbar@healthinsight.org
(505) 998-9761
Cardiac Disparities Data: Health Disparity Reduction Efforts
Disparities NCC
October 1, 2013
IHPC Team

Virginia Brooks, MHA, CPHQ
Director, Prevention
vbrooks@vaqio.sdps.org
804-289-5343

Sharon Alloway, MHA
Area Manager, Prevention
salloway@vaqio.sdps.org
804-289-5339

Geri Stahl, BS
Area Manager, Prevention
gstahl@vaqio.sdps.org
804-289-5344

www.vhqci.org

Cardiac LAN Overview

- Cardiac LAN consists of medical experts, community partners, federal and state agencies, physician offices and pharmacists.

- Work focuses on aspirin therapy, blood pressure control, cholesterol control and smoking cessation (ABCS).

- 67 practices including primary care and cardiology from two health systems in Virginia
  - 38 BSMG practices with 138 providers
  - 35 RMG practices with 145 providers
## LAN Activity: Data

### Cardiac Population Health Learning & Action Network Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>NQF 0068: Ischemic Vascular Disease (IVD): Use of aspirin or another antithrombotic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin</td>
<td>NQF 0073: Ischemic Vascular Disease (IVD): Blood pressure management</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>NQF 0075: Ischemic Vascular Disease (IVD): Complete lipid panel and LDL control</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>NQF 0028: Preventive Care and Screening Measure Pair: (a) tobacco use assessment and (b) tobacco cessation intervention</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td></td>
</tr>
</tbody>
</table>
Purpose

• Compare national and statewide trends to our local LAN populations.

• Determine how to focus our interventions that we are offering our LAN members.

• Analyze data to identify specific types of community partners.

Smoking Data

<table>
<thead>
<tr>
<th>Population</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total patients</td>
<td>124,927</td>
<td></td>
</tr>
<tr>
<td>Patients assessed for smoking</td>
<td>102,135</td>
<td>81.7%</td>
</tr>
<tr>
<td>Patients not assessed for smoking</td>
<td>22,792</td>
<td>18.3%</td>
</tr>
<tr>
<td>Patients assessed for smoking who do not smoke</td>
<td>86,873</td>
<td>85%</td>
</tr>
<tr>
<td>Patients assessed for smoking who do smoke</td>
<td>15,262</td>
<td>15%</td>
</tr>
<tr>
<td>Smoker - not offered an intervention</td>
<td>5,679</td>
<td>37%</td>
</tr>
<tr>
<td>Smoker - offered an intervention</td>
<td>9,583</td>
<td>63%</td>
</tr>
</tbody>
</table>
### Smoking Data Findings Based on Race and Gender

<table>
<thead>
<tr>
<th>Race</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>W = Caucasian</td>
<td>83,963</td>
<td>67.21%</td>
</tr>
<tr>
<td>B = Black</td>
<td>32,696</td>
<td>26.17%</td>
</tr>
<tr>
<td>U = Undetermined</td>
<td>6,168</td>
<td>4.94%</td>
</tr>
<tr>
<td>O = Asian</td>
<td>1,612</td>
<td>1.29%</td>
</tr>
<tr>
<td>F = Filipino</td>
<td>2</td>
<td>0.00%</td>
</tr>
<tr>
<td>N = American Indian/Alaska Native</td>
<td>275</td>
<td>0.22%</td>
</tr>
<tr>
<td>P = Pacific Islander</td>
<td>181</td>
<td>0.14%</td>
</tr>
<tr>
<td>H = Hispanic</td>
<td>30</td>
<td>0.02%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>73,624</td>
<td>58.93%</td>
</tr>
<tr>
<td>Male</td>
<td>51,300</td>
<td>41.06%</td>
</tr>
<tr>
<td>Total Patients</td>
<td>124,927</td>
<td></td>
</tr>
</tbody>
</table>

### Smoking Data Significant Findings

- Male smokers are more prevalent than female smokers (16.0% vs. 14.2%).

- There are slightly more black smokers (15.5%) than white smokers (14.9%).

- There are slightly more white females (14.7%) who smoke than black female smokers (13.6%).
Smoking Data Significant Findings

- There are more black male smokers (18.9%) than white male smokers (15.1%).

- Female smokers are 1.4 times more likely than male smokers to receive smoking intervention (66.1% vs. 58.6%).

- Black smokers receive smoking intervention more than white smokers (64.2% vs. 63.0%).

Recommendations

- **Data Source:** Utilize EHRs to capture disparity data

- **Analysis:** Analyzed data and compared to National trends from CDC and BRFSS data

- **Advice:** If you’re able to access the data, make sure you fully understand it. Helpful to have a data analyst perform statistical analysis
Recommendations

**Challenges:** Focused on one health system because the other was unable to pull the data

**Successes:** Targeted specific interventions and determined high and low performers

Next Steps

1. Site visits with practices to review data and trends.
2. Provide education and resources on smoking cessation and heart health geared toward populations that show a higher need.
3. Focus on a condition with high patient volume.
4. Highlight findings in a newsletter.
Questions?

QIO MODERATED PANEL

Questions?

Comments?

Reactions?
Disparity Lessons from Great Recession on Health Care Costs

STEPHEN B. THOMAS, PhD
FOUNDING DIRECTOR OF THE MARYLAND CENTER FOR HEALTH EQUITY
PROFESSOR OF HEALTH SERVICES ADMINISTRATION IN THE SCHOOL OF PUBLIC HEALTH

JIE CHEN, PhD
ASSISTANT PROFESSOR, DEPARTMENT OF HEALTH SERVICES ADMINISTRATION
SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF MARYLAND

SAVE THE DATE!
DATA DRIVEN ACTION: PATHWAYS TO HEALTH EQUITY
October 1, 2013
12:00-4:30pm EST
Lessons From the Great Recession: Disparities in Health Care Costs

Jie Chen, PhD
Assistant Professor
Department of Health Services Administration
School of Public Health
University of Maryland
College Park, MD

HOW DID THE RECESSION IMPACT THE PEOPLE YOU SERVE?
The recession could have had heterogeneous effects across the distribution of health care expenditures

Elastic primary and preventive health care services (\$100 plus)

VS

Inelastic, expensive, and intensive health care services (\$10,000 plus)
Total Health Care Expenditure ($) during 2008-2009

<table>
<thead>
<tr>
<th>mean</th>
<th>Percentiles</th>
</tr>
</thead>
<tbody>
<tr>
<td>4905</td>
<td>10% 166 25% 487 50% 1523 75% 4612 90% 11424</td>
</tr>
</tbody>
</table>

How about disparities in health care spending patterns by race and ethnicity?

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Low spending</th>
<th>High spending</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>White</td>
<td>0.39</td>
<td>0.61</td>
</tr>
<tr>
<td>Latino</td>
<td>0.34</td>
<td>0.16</td>
</tr>
<tr>
<td>African American</td>
<td>0.19</td>
<td>0.17</td>
</tr>
<tr>
<td>Asian</td>
<td>0.06</td>
<td>0.03</td>
</tr>
<tr>
<td>Other race</td>
<td>0.02</td>
<td>0.03</td>
</tr>
</tbody>
</table>
Study Design

- Health care expenditure
- Quartile Regression
- Difference-in-Difference method

Results

The Great Recession was associated with significant drops in health care expenditures, particularly at the lower end of its distribution (primary care).
Results

No significant relationship between the recession and health expenditures at higher distributions of health care spending (intensive medical interventions).

Results

Inexpensive primary care spending DOWN and Expensive medical care spending UP
Significant Racial and Ethnic Disparities

- Racial and ethnic disparities were more substantial at the lower end.
- Disparities persisted during the recession.

Data Driven Policy Action

The importance of providing cost-effectiveness treatments during economic crisis

- Primary care
- Preventive care
- Prescription drug use
Data Driven Policy Action

Value of the Affordable Care Act

1. Essential Health Benefits
2. Expansion of eligibility in Medicaid
3. The state-based Marketplaces/Health Exchanges

Conclusions

All of these ACA provisions

1. Reduce the burden of health care spending for low-income families
2. Help to close racial and ethnic disparities in health care spending
THANK YOU