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Welcome and happy new year. Thank for joining the first community call of 2014. Today's topic is the -- all lines will be muted it. We'll have question and answers and all participants are encouraged to submit questions via the webex. We are recording this call and will post slides on the healthcare communities and website. Everyone be sure to fill out the evaluation. It is with great pleasure I introduce our keynote speaker Dr. Shanta Whitaker. She received her masters in philosophy in Ph.D from Yale university. In an evident to apply a more focused career. She completed her masters of health at the Johns Hopkins Bloomberg school of public health. She focused on health disparities and is working to address des parties. Also speaking is the health data analyst. During the time at Delmarva he has had a leading role in data reports with the DNCC. He has a masters in epidemiology from the university of North Carolina, chapel hill. Without further ado, I'll pass it over it Dr. whitt ti Kerr.

Good afternoon. Before we get started, I thought it would be a fun activity to have everyone participate in a poll question. Sense we're presenting a business case, I want it get a sense of what is the most chronic condition you're seeing among Medicare patients. Is it diabetes, chronic kidney disease, chronic obstructive pulmonary disease. Congestive heart failure or mood disorders. Please pick the one that best fits you.

Again, I can't wait to see what the response are. But let's get to the presentation.

We will consider costs. But, first the question lingers, why are health des parties so important? It starts with 2002 when it released unequal treatment. This report outlined why des parties exist.

A few years later in 2009, the joint center for political and economic report estimated the costs associated with health disparities. About 229 billion for direct Medicare expenditures and another \$1 trillion for indirect costs, also including loss of productivity and care from care gives. There are other des parties that -- disparities that are prevalent. In a lot of cases men have disparate outcomes. We have to think about rural versus urban. Next, we have to consider dual eligible. As we know from our work, dual eligibles are often sicker and have a lot more issues. So why are we here? Chronic conditions cost Medicare lots of money. As you know, as a person has more and more chronic conditions, the more it will cost Medicare. There have been studies to quantify them but most of these studies -- none of these studies, only one or two have started to think about disparities and these haven't focused on the Medicare population. So we want to provide an actual value to the financial burden of health disparities. It has implications on how Medicare can save money. So our goal, as -- to just summarize is to determine the cost to Medicare, specifically focusing on part A. With that I'm going to turn it over to Alex so he can go over or methods.

Our study population -- population is 2011 Medicare part A. Beneficiaries were identified by race, ethnicity, gender, dual eligible status and zip code. All of that is coming from the Medicare beneficiary file. The determined cost using Medicare part A inpatient claims from the QIO claims data warehouse, these are fee for service only -- I'm sorry, I should have also said the population includes, eligible for part A and only Medicare beneficiaries who are not enrolled in an HMO for the year. This is somewhat relevant because we found that the participation rate in Medicare HMO is different by -- varies by race. It's particularly high in hispanics. Sorry for that digression. Medicare part A inpatient claims. Claims were classified as diabetes, congestive heart failure or mood disorders based on HCUP's ICD9 classification codes. It has one or more disease, so they are not exclusive categories. Also, the claims were only for diabetes and congestive heart failure, we only looked at short term and acute care hospitals. For mood disorders as well as psychiatric hospitals. The cost associated on the axis of race, ethnicity, gender, dual eligible status and urbanization. We took urbanization by linking the beneficiary zip code to a rural urban classification as determined by the 2010 census. The dual eligible status is the counted Ben if I'm -- beneficiary if they had the state buy into that your insurance. That just about covers the methods. So I'm going to turn this back over to Shanta.

Thank you, Alex. So before we get into the data, let's do one last poll question. In a few minutes I will present our analysis of cost with diabetes, chronic kidney disease, chronic obstructive pulmonary disease, congestive heart failure and mood disorders. Which would you say has the highest cost. Would you say it was minorities, those living in rural areas. Would you say it was male, dual eligible or those living in poverty. Yay for participating. We'll start with diabetes. As you know diabetes impose as serious economic burden on our healthcare system. In 2012 it cost the United States \$245 billion and about \$69 billion in lost productivity. Of concern to us is that about 59% of the healthcare expenditures associated with diabetes are for those 65 years and older. So in this graph, what -- what we're showing you in this graph, the cost differences using white as the reference group looking at diabetes cost among hispanics or Latinos, blacks, Asian or Pacific islanders or American Indian. They have a higher cost compared to whites. Very interesting -- it was very interesting to us to see the high cost associated with the blacks and hispanics. Blacks had about \$3 billion in expenditure compared to whites while hispanics had about \$585 million compared to whites. Moving on to -- looking at dual eligible status and gender. Starting with the dual eligible, those who are dual eligible compared to those who aren't. As you can see there's a substantially higher cost associated with diabetes compared to those who don't have dual eligible status. About \$7 billion in excess cost. When we look at gender, males have a substantially higher cost associated with diabetes compared to females. Then we also looked at urbanization. So just to give you a quick reference, when we say urbanized area, it's an area that has a larger than 50,000 people. An urban cluster is about 2500 to 50,000 people and rural is less. Rural will be less than 2500 people. As you can see, looking at the urbanized areas, urban, people who live in urban areas have a higher cost associated with diabetes compared to those in rural areas. The next chronic condition we studied was congestive heart failure. It results in nearly 1.4 million -- 1.4 million hospitalizations and \$17 billion. It usually has comorbidities which places an even greater burden on the healthcare system. So, again, we're going to start looking at the cost associated with congestive heart failure by race/ethnicity and whites are the reference group. Asian or Pacific islanders are less. Blacks along with hispanics and Latinos. Next we're going to look at dual eligible status. Again, as you can see, the dual eligibles have a substantially higher cost for congestive heart

failure, about \$1.4 billion. When you look at gender, males are costing more, \$1.3 billion compared to females. Looking at urbanized areas versus -- urbanized clusters. People living in urban areas cost more than those in rural areas based on the measures we're using here. Now for the last chronic condition that we're going to include in this presentation is to discuss mood disorders. Mood disorders are associated with a loss of work productivity and a reduced quality of life. In this study, well, mood disorders include depression and bipolar disorder. Depression is often associated with substantially high medical costs and associated with other chronic conditions. So when we look at the cost of to medicare for mood disorders, interestingly, asians cost about \$153 million less than whites. Then for African-Americans, hispanics or Latinos, American Indian and American Indians cost more. Next we'll look at dual eligibility. As you can see with those who are dual eligible cost Medicare about \$4.6 billion more than those who are not dual eligible. Then when we look at gender, interesting, if you have noted, males have cost Medicare more than females but this is a reverse. Here males cost about \$2.7 billion less than females.

Then, again, by urbanization. Urbanized area compared to a rural area cost Medicare about \$3.1 billion more. Just to summarize the data we just went over and hopefully I didn't go over it too quickly for you and we will right slides later as well, nonwhites consistently have higher inpatient costs for diabetes and congestive heart failure. Asians cost Medicare approximately \$153 million less for mood disorders than whites. Males cost Medicare more for all chronic conditions analyzed except for mood disorders. Dual eligibles had a higher cost compared to those who are just utilizing Medicare only. As far as urbanization, beneficiaries cost Medicare more than those residing in an urban cluster or rural area. So just to conclude our portion of this CoP call, health disparities pose a major economic burden -- an economic disparity to healthcare. For example, if I added the cost associated with racial and ethnic minorities that were included in the studies, the costs associated with diabetes for hispanic Latinos, blacks, Asian or Pacific islanders, cost \$3.9 billion more than whites. So this is just to help us start thinking. Not to say this presents a full range of -- that's not what I'm trying to say. What I'm trying to say, what we were hoping that you get from our business case is the fact that disparities are costing Medicare a lot of money and we really need to get to the root cause of why this is going on and address these disparities and more studies need to be undertaken to really understand the costs because it will help in the development of targeted -- targeted intervention to reduce Medicare associated costs.

Thank you, Dr. Whitaker for reviewing the business case analysis for us and helping put the cost of Dells patients into -- disparities into question. These are the references. If you'd like it get more information on the subject, please feel free to visit the website listed here -- listed here. Now we will start with the discussion. Kimberly Irby from the integrating care for populating communities, ICPC, NCC. She directs work supporting QIO's across the country. With that. I will pass things off to Kimberly.

Thanks, Ava. I want to congratulate you on putting so much day that out. I want to say I work a lot with the analysts and there are a lot of things analytically we want to talk more but I don't think today is the right place for that but I want to -- I think it will be a great outlet to talk about how to approach it analytically and interpret some of the results. The ICPC, I want to talk about some of the things that falls in line with what you guys have shown as well. We don't see a huge difference between urban and rural because you guys did see some differences. As pointed out

our biggest differences lie in the dual population, the dual population is about 75% higher than the nonduals. With regard to readmission, the duals are about 130% higher than the nonduals. There's a huge population there that we could all work on together. I also wanted to take some team to talk about two examples that we have been told about across the ICPC communities. There's one in Mississippi where it's on the eastern side of Mississippi and Meridian, they have deployed two social workers and nurses to that area to really work with African-American beneficiaries around diabetes self-management to really reduce patients in the area. You talked about how amputations are higher in the African-American population around diabetes. That's a really good example of what's going on in the communities. Of this he done a lot of work. They have quote unquote graduated 160 beneficiaries in the area who have better management and who are caring for it much about.

The other example I wanted to talk about is coming out of northern Arizona, there's a reservation in northern Arizona. It's about 70-miles from the next biggest city in Arizona and they have done a lot of work there around mobile health. So the native Americans don't come up with reservations that often to see a physician. They have brought mobile technology into the community and they're able to transmit through cellular service to a mors who sits in an office in Flagstaff. She talks with the patient and has done a lot to reduce readmissions. They have created a video about this effort that's happening in northern Arizona and if I could share that link with Shanta and Ava, they can send it out. It's about three minutes and it's quite moving. I thought that would be interesting to see real life examples of how communities are working. So as far as the ICPC work, my team is interested in learning about poverty and how it's interlaid. I think rowrn and urban is a good's to start but we would like to get to a gran few lar level -- granular level. I would ask the group to speak up if you have work going on around your area and how you have addressed that.

If you would like to pose your questions or share your story, press one on the phone or you condition use the chat box feature.

We're going to weight a few more minutes. Locks like we have one.

I want to echoette notion that it would be really great if we could get more granular geographic information. Unfortunately, at least for our data, we were just working with claims data and I know that. I assume some of you -- we're sort of stuck with zip code and have to be happy to get that. So I totally agree but we're at least for large studies like this will come up against the limits. Do we try to lobly CMS for better coding of data.

What we are thinking of doing right now is trying to put addresses into a census track and trying to pull it using the census data.

If you have any success with that. I do have experience doing geocoding. It's the approved statistical instrument and you can do that with that. Any success you have, I would be interested to hear and I'm sure others would as well.

We find it to be promising. We think it might offer more information than what's out there right now. I agree we are handcuffed to get at these problems.

That would be awesome. The other thing I want to interject is our definition of rural urban or rural and urban clustered areas. We're row purposing data from the census. There's a little self-criticism here because this was kind of my idea originally at the NCC. They are definitions that work well for sun sus purposes but don't work fan tascally when you look at healthcare and quality improvement processes. We find that the numbers are extremely unbalanced. There's almost -- the overwhelming majority of people end up being put in an urbanized area and very few in a rural area, which is increasingly true but probably not quite the extent that our data show, so trying to find a good consensus for how we define rural and urban would be, I think, a priority. I know there's been some discussion about trying to define that in terms of what services are available and we've looked at that very previously but want dug into that at the DNCC.

Thank you Alex and Kim. We do have a question in the qiew -- queue. Can speakers repeat population numbers that define urban versus rural cluster versus nonurban.

An urbanized area is greater than 50,000 people. Urban cluster is 2500 to 50,000 and rural is 2500 or less.

So Janice, I hope that answered your question adequately. Next, we'll move to the midwest in Oklahoma, former nurse and tenure veteran will begin the discussion portion. Dr. Allen ma and Dr. Wato Nsa. They bring invaluable information and together have more than 30 years of experience. So with that, our colleagues from Oklahoma will take over.

Thank you. This is Kathy Maffry. We do. -- we agree that there are -- that there are disparities in the healthcare delivery and this report is a great start to help us open our eyes and realize that. Increased cost associated with the care. When we improve individual patient care, we're not always focused, at least in our NCC on the chronic conditions but to spread practices and innovations that can help decrease those costs and reduce and eliminate the disparities. When Kim shared the information with Arizona and that work even in Mississippi, that's such a good start if we can drill down into the QIO's because as we talked to the NCC's they don't always have the greatest access to the data. So to have the information to share and spread with others, then maybe we can make a good impact of that. Although we're focused on the overall chronic conditions, we have some learning moments and we experience, when trying to interpret data relative to disparities. We try to identify hidden costs in healthcare that you can't find in the claims data, trying to use multivariant analysts to consider disparities because it may not be the area. It may be within that facility there's even disparate care but trying to find that -- compare that with others as well as those in the region and the national level. And, again, we do try to use those mentor facilities and find those innovative programs. If we can do that on the more detailed calls that I think the DNCC has coming up, that would be great. I'm curious for the other QIO's, have you examined other ways to control costs like costs of medications that are post discharge. Do you see a need maybe for training to analyze the difference between hospitals versus within hospitals and within facilities of how that disparate goes. We tried looking at a bunch of things ourselves. I'm curious to get some of your feedback on ways you might have looked at this. Thank you, Ava, for this time and if there's any question, we'll see what we can do.

Thank you, and want to reiterate her question. If any QIO's are on the line if you have examined other ways for controlling claims data post discharge or if you perceive a need for training to rec fize and analyze the deference between hospitals versus within one hospital or facility, please share your experiences with us. Again, you can do that by pressing 14 on your phone or using the chat box feature.

Ava, this is Cathy again. Looking at healthcare associated infections about using data, which we don't have that. We don't have that level of detail for the beneficiaries. Are there any QIO's that are able to use patient level data to help make the case for controlling infections and finding those disparates. disparates-- disparities.

We're going to give participants about 30 seconds or so if you do have questions concerning Cathy's questions if you have patient level data. Please share that with us.

I guess par ties pats are a little shy -- participants are a little shy today. We'll move to the east coast where the program manager and Erica Morrison community practice manager for improving health for populations and communities will expand on cardiac diseases highlighting the C9A. They provide a unique outlook, clinical experience and program many pleamentation. We'll turn things over to Jo Hannah and Erica.

Kudos for this. I can speak to heart failure as it relates to general cardiac health. First, let me say that heart failure is a disease that ans on of prevention would be worth 10 pounds of cure if there was a cure. Unfortunately, there's no cure for heart failure. So the goal we're talking about here is prevention and once it is diagnosed, manage the symptoms through outpatient programs that are for the most part right now developed by large hospitals. Heart failure, it ties for the number two diagnosis for its admissions but it's the number one diagnosis for readd mismghts the -- readmission. The current ones are the direct and indirect costs to treat heart failure could more than double from 317 million in 2012 to 70 until 2030. There's one hear that's a -- area that's a little bit of an opportunity. Less than 25% of African-Americans with heart failure are receiving the guideline recommended therapy for this disease. So there's a little bit of opportunity to improve there. He'd like to talk about the strat -- I'd like to talk about the strategies. They center around patient, life-style and management at him or through a heart clinic and increased access to heart failure clinic. All of this is trying to address income disparity. There are programs that are looking at this. They launched a three-year heart failure initiative a few months ago in November of 2013. Their strategies that they're focusing on are increased prevention, increased treatment access, empowering the patient and the caregivers. Transforming the perception of heart failure. Targeting those geographic areas with the highest number of heart failure patients and developing unique resources to help answer the questions and concerns around heart failure. Another program that's shown some traction is the American heart association gets with the guidelines it. Includes 100,000 hospitalized patients and they have some good experience there and some encouraging results. The third program that is really kind of a resource that might be a help to look at is the heart failure society of America, that professional association. It's a wonderful resource. I'd like to know from the QIO's if they're seeing access issues with clinic-based heart failure programs or home based programs since they tend to be run by large hospitals and not necessarily in those rural areas where you know that the income disparity need might be

the greatest. If they're seeing access issues with heart failure programs. And I'm going to turn it over to Erica at this point.

Another question to piggy back on Jo Hannah, in addition to whether there's an access issue, those that are working in your area or your state. We'd be happy to hear back from the participants. Thank you, Ava.

Thank you Erica and Jo Hannah. Please share with us through the chat box feature by pressing 1-4 or programs that coordinate with primary care as Erica has addressed.

If we have no questions, we will hand things back to Shanta so she can expand more.

Thank you. I thought it would be good to bring it all together. Thank you to all the NCC's who participated on the line. We truly appreciate the time for this initial, our first CoP call for the year. I thought it would be interesting to briefly wrap up the call with a discussion about how this information could potentially be useful. So our -- one of our main goals is to reduce cost and to improve quality. Understanding the population with the poorest outcomes and that are costing the most we can target resources and interventions for quality improvement and cost savings. We can start to think about engaging stakeholders and minority health initiatives or other areas of disparities. How do we engage the stakeholders. Another way is to show them the cost. Show them how much a disparity can cost their particular healthcare system. Tracking progress and reducing health disparities, it will be important to think about cost analysis and impact analysis for interventions for the most vulnerable constituents. So I just wanted to leave you with some questions to ponder. Maybe if you have a chance to come back on with our office hours next week. We see there are costs associated with chronic conditions. So now what? What are the next steps? What are some action items that we can focus on to reduce costs? We also need to think about moving past this idea of a silver bullet. One action, one thing is not going to eliminate disparities. We need to think about collaborative efforts to really drive down costs and drive down health disparities. So we also need to make sure that we are considering the social determinants of health at all points. Why do you think that focusing on individual health has not fully eradicated these disparities. I think it's time that we need to think about the environment that the -- that our beneficiaries are living in. We need to think about where they're playing, where they're worshipping, what they're eating, consider all of these things that can play such an important role on their health outcomes. Also, considering engaging in the community. I know that's very important and it's going to be even more important as we move forward in all of our work. What community partners will be eventual for reaching the populations described in this presentation. What organizations will be the most important for making an impact in our communities and with that, I'll turn it over to Ava, just something to think about and if you feel like sharing, either send us an email. You can -- also, we'll be online next week for the office hours. I really welcome a discussion.

Thank you, Shanta. And, again, if anyone has any questions, feel free to pose them at anytime. I want to thank our QIO and NCC partners. You did a good job in provoking questions and the conference you engaged us in. We want to move into a few quick announcements, the DNCC virtual training page set up and running. Please, check it out today. Check out the CMS pulse website. And, also, make sure you stay current on everything that the DNCC is doing. So the

upcoming events include our office hours that will take place next Wednesday, January 22 and from 2 p.m. to 3 p.m. During that time Dr. Whitaker will lead us in the discussion about the business case and finally presents our next call is Tuesday -- analysis. Our next call is Tuesday, February 11th. As always, feel free to share your success stories with us. You can email me personally or call me if you have anything to share. I want to thank Dr. Witt Kerr and Alex for -- Whitaker and Alex. And it looks like we have a question in the queue. Will DNCC release state data analysis results?

Not for the business case, no.

And if participants have any other questions, we will hold on the line.

Though this business case will not be -- we're not going to present state level for this, however, at the end of the month, we will be releasing the cardiac disparities report that uses the behavioral risk factors surveillance system data and those -- we sent out an email recently asking for points of contact for these reports, but, yes, we will be sending those out and those will be at the state level.

Also, we will be releasing state level hospital care -- state level hospital conditions, and that's nursing home related HHC. That will also be coming out at the end of the month.

I want to remind everyone to please complete our evaluation at the end of the call. As mentioned, we will stay around to take any more questions that participants may have.

Seeing there are no questions, that will conclude our call. Thank you for joining and we look forward to seeing you online next month. [Event concluded]