hot topics in practice

Northwest Center for Public Health Practice
UNIVERSITY of WASHINGTON

Data for Addressing Health Disparities

Teresa Litton, MPH, CPH

Project Manager, Performance Improvement; Washington Health Alliance

WASHINGTON HEALTH ALLIANCE
Leading health system improvement

www.nwcphp.org/hot-topics

Discussion question

What are some health disparities you are addressing at your agency?

Please type your answer in chat box.

Background

Disparities in health care

- What are disparities?
- Populations affected
- Why these disparities matter

What are disparities in health care?

Health disparities refer to differences in health and health care received between groups of people.

These differences can affect how frequently a disease affects a group, whether a group receives appropriate care for their disease, or how often the disease causes disability or death.

--Institute of Medicine

The goal is Health Equity

Health equity is “the attainment of the highest level of health for all people.”

–Healthy People 2020

Many populations affected by disparities

- Racial and ethnic minorities
- Rural areas
- Women
- Children
- Elderly
- Persons with disability

Disparities are typically associated with **underuse of effective care** and impacted by the **social determinants of health.**

Reasons why disparities matter

Health - Minority patients often experience worse health and receive lower quality of healthcare

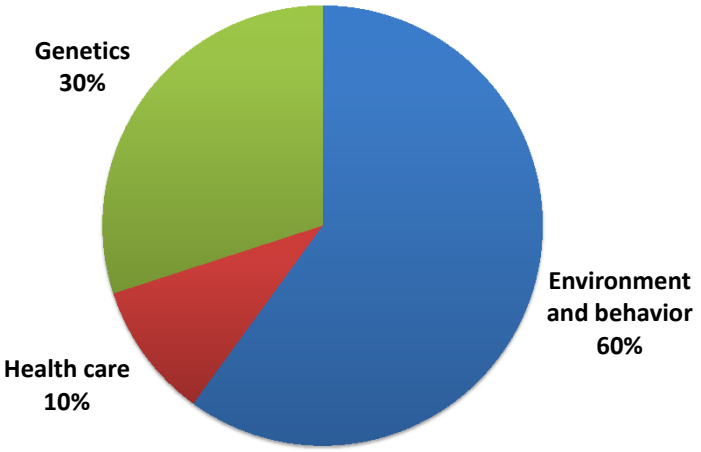
Business - a financial burden on health care systems and drain on the economy

Ethical - it's a human rights issue

Risk management

Legal - it's the law

Health care accounts for 10% of health



Source: *New England Journal of Medicine.* We Can Do Better Improving the Health of the American People, Sept. 2007

Learning Goals

- Define and describe the Washington Health Alliance
- Describe the data available from Washington Health Alliance
- Identify 5 key findings from the 2014 Disparities in Care report

About the Alliance

Who We Are

- **Multi-stakeholder**.
  - More than 175 member organizations representing purchasers, plans, providers, and patients
- **Purchaser-led.**
  - The majority of board members represent employers and labor union trusts
- **Non-profit.**
  - Designated 501(c)3
- **Data-driven.**
  - claims data on 3.3 million lives in Washington (commercially and Medicaid)
- **A convener.**
  - A place where those who give care, get care, and pay for care come together to lead health system change

Mission and Vision

Mission

The Alliance's mission is to build and maintain a strong alliance among purchasers, providers, health plans, consumers and others to promote health and **improve the quality and affordability** of the health care system **by reducing overuse, underuse and misuse** of health care services.

5-Year Vision

By 2017, our vision is that physicians, other providers and hospitals in Washington will have **achieved top 10% performance in the nation** in the delivery of equitable, high quality, evidence-based care and in the reduction of unwarranted variation, resulting in significant reduction in the rate of medical cost trend.

Convening

Innovation and transparency

- All Payer Claims Database
- Delivery reform activities

Impacting supply

- Quality Improvement Committee
- Health Economics Committee

Impacting demand

- Consumer Engagement Committee
- Purchaser Affinity Committee

Triple Aim

High Value Care

Measurement and reporting

Quality and underuse

- Community Checkup
- Disparities in Care
- Your Voice Matters (patient experience)
- eValue8 (evaluating payers)
- *Potentially avoidable readmissions*

Price

- Price variation
- Value portfolio

Overuse

- Choosing Wisely
- Resource use during high-volume hospitalizations
- *Potentially avoidable ED visits*
- *Preference sensitive procedures*

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2014 Disparities in Care report

Methods

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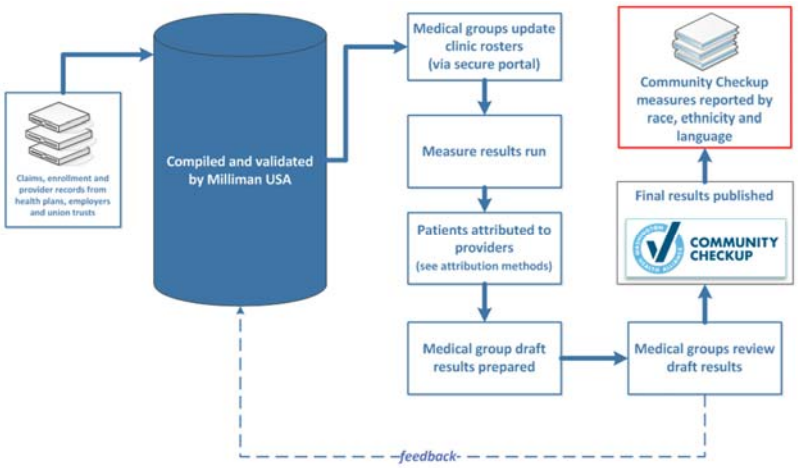
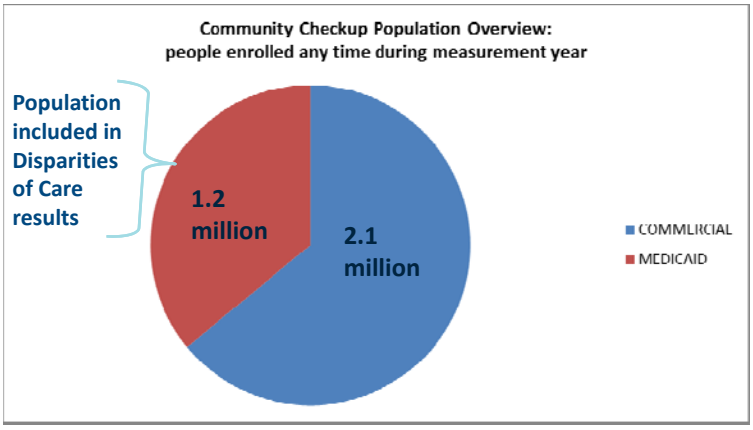
Community Checkup and Disparities data process



Overview of data

Health Care Authority has race/ethnicity/language information on Medicaid members



About the data in the 2014 report

- Medicaid population who received full insurance benefits from July 1, 2011 to June 30, 2012
- Stratified by race, ethnicity, and language
- Only Medicaid enrollees eligible by low income
- Wilson Score Interval test, 95% Confidence Interval

Data Limitations

- Limited to one data set
  - Other data suppliers do not ask for race, ethnicity and language
- Underreporting
  - i.e. free clinics or tribal clinics
- Regional rate includes all enrollees
  - Including those with “Unknown Race” or “No Race Data”

2014 Disparities in Care report

Key Findings

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KEY FINDING 1: Medicaid enrollees receive lower rates of appropriate care compared to commercially-insured populations across several quality domains

Figure 2. Health screenings and access to care received by Medicaid enrollees compared to commercially-insured populations, 2011-2012

Red= Medicaid rate is significantly worse than commercial rate; Green= significantly better; Gray=not significantly different.*

QUALITY MEASURE	STATEWIDE MEDICAID RATE	STATEWIDE COMMERCIAL RATE
Health screenings		
Adolescent well-care visits – Ages 12-21 yrs	27 %	31 %
Screening for breast cancer - Ages 52–69 yrs	45 %	68 %
Screening for cervical cancer – Ages 21-64 yrs	61 %	69 %
Screening for chlamydia – Ages 16-25 yrs	48 %	40 %
Screening for colon cancer – Ages 51-57 yrs	35 %	51 %
Access to care		
Child & adolescent access to primary care - Ages 12–24 mths	89 %	91 %
Child & adolescent access to primary care - Ages 2–6 yrs	73 %	79 %
Child & adolescent access to primary care - Ages 7–11 yrs	74 %	79 %
Child & adolescent access to primary care - Ages 12–19 yrs	70 %	79 %
Adult access to preventive/ambulatory care - Ages 20–44 yrs	81 %	87 %
Adult access to preventive/ambulatory care - Ages 45–64 yrs	86 %	93 %
Adult access to preventive/ambulatory care - Ages 65+ yrs	89 %	89 %

**Significance was calculated using a chi square test. P-value = 0.05.*

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KEY FINDING 1: Medicaid enrollees receive lower rates of appropriate care compared to commercially-insured populations across several quality domains

Figure 3. Disease specific care received by Medicaid enrollees compared to commercially-insured populations, 2011-2012

Red= Medicaid rate is significantly worse than commercial rate; Green= significantly better; Gray=not significantly different.*

QUALITY MEASURE	STATEWIDE MEDICAID RATE	STATEWIDE COMMERCIAL RATE
Diabetes		
Blood sugar (HbA1c) test – Ages 18-75 yrs	81 %	88 %
Cholesterol test (LDL-C or bad cholesterol) – Ages 18-75 yrs	67 %	79 %
Eye exam – Ages 18-75 yrs	51 %	60 %
Kidney disease screening – Ages 18-75 yrs	75 %	81 %
Asthma		
Use of appropriate medication – Ages 5-64 yrs	84 %	91 %
Chronic obstructive pulmonary disease (COPD)		
Use of spirometry testing in assessment and diagnosis of COPD - Ages 40+ yrs	38 %	44 %
Depression		
Antidepressant medication (12 Weeks) – Ages 18+ yrs	51 %	68 %
Antidepressant medication (6 Months) – Ages 18+ yrs	34 %	51 %
Heart disease		
Cholesterol test (LDL-C or bad cholesterol) – Ages 18-75 yrs	72 %	82 %
Cholesterol-lowering medication– Ages 18-75 yrs	68 %	72 %

**Significance was calculated using a chi square test. P-value = 0.05.*

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KEY FINDING 1: Medicaid enrollees receive lower rates of appropriate care compared to commercially-insured populations across several quality domains

Figure 4. Appropriateness of care received by Medicaid enrollees compared to commercially-insured populations, 2011-2012

Red= Medicaid rate is significantly worse than commercial rate; Green= significantly better; Gray=not significantly different.*

QUALITY MEASURE	STATEWIDE MEDICAID RATE	STATEWIDE COMMERCIAL RATE
Appropriate use of care		
Avoidance of antibiotic treatment in adults w/ acute bronchitis – Ages 18-64 yrs	23 %	24 %
Avoidance of antibiotics for common cold – Ages 18-64 yrs	91 %*	91 %*
Avoidance of X-ray, MRI and CT scan for low back pain – Ages 18-64 yrs	85 %	87 %
Use of generic prescription drugs		
Antacid medication (Proton Pump Inhibitors)	93 %	86 %
Antidepressants	90 %	88 %
Cholesterol-lowering drugs (Statins)	75 %	77 %
Medication for ACE inhibitors or angiotensin II receptor blockers (ARBs) used to treat high blood pressure	93 %	88 %
Medication for attention deficit hyperactivity disorder	68 %	63 %

**Significance was calculated using a chi square test. P-value = 0.05.*
**Note: Avoidance of antibiotics for common cold rates for Medicaid=91.4% and commercial=90.8%, are statistically different*

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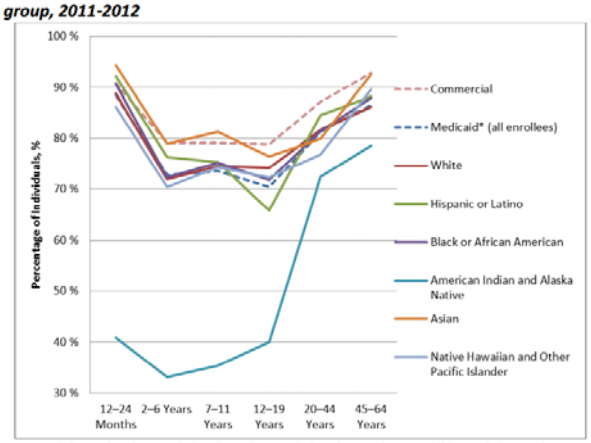
KEY FINDING 2: Disparities in access to primary care are greatest for young children, adolescents, and Native American populations

Figure 3. Child and adolescent access to primary care and adult access to ambulatory/preventive care among Medicaid enrollees, by racial/ethnic group, 2011-2012



*The Medicaid rate includes all enrollees, including those without available race/ethnicity data.

KEY FINDING 3: Quality of diabetes care varies among racially and ethnically diverse Medicaid enrollees

Figure 4. Quality of diabetes care among Medicaid enrollees, 2011-2012*

Red= Medicaid rate is significantly worse than commercial rate; Green= significantly better; Gray=not significantly different.*

DIABETES MEASURE	STATEWIDE MEDICAID RATE	HISPANIC/ LATINO	BLACK OR AFRICAN-AMERICAN	AMERICAN - INDIAN/ ALASKA NATIVE	ASIAN	NATIVE HAWAIIAN / PACIFIC ISLANDER
Blood sugar (HbA1c) test	81 %	81 %	81 %	64 %	86 %	84 %
Cholesterol test (LDL-C or bad cholesterol)	67 %	62 %	64 %	52 %	76 %	69 %
Eye exam	51 %	49 %	51 %	40 %	63 %	56 %
Kidney disease screening	75 %	72 %	78 %	70 %	80 %	81%

*Rates for White enrollees are not included in this Figure as their rates are not significantly different from the regional Medicaid rate for any diabetes measure.

KEY FINDING 4: Rates for health screenings among Medicaid enrollees vary by type of service and beneficiary race/ethnicity

Figure 5. Cancer screening among Medicaid enrollees, 2011-2012*

Red= Medicaid rate is significantly worse than commercial rate; Green= significantly better; Gray=not significantly different.*

RACIAL/ETHNIC GROUP	CANCER		
	BREAST	CERVICAL	COLON
Medicaid* (All Enrollees)	**45%**	**61%**	**35%**
White	**44%**	**59%**	**35%**
Hispanic or Latino	**49%**	**71%**	**36%**
Black or African American	**45%**	**64%**	**34%**
American Indian and Alaska Native	**40%**	**56%**	**30%**
Asian	**56%**	**61%**	**33%**
Native Hawaiian and Pacific Islander	**46%**	**64%**	*

**There were too few patients (less than 160) with the condition of interest to meaningfully report on this measure.*

Recommendations

- **Standardization**
  - Processes and procedures to ensure predictably effective care(Embedding, monitoring, and supporting)
- **Personalization**
  - Framing care that's tailored to the patient's culture, socioeconomic, language, health literacy
    - Improving cultural competency training
    - Improving care coordination
    - Providing tailored health education
- *Every patient. Every time.*

Disparities in care: Resources and activities

Disparities in care: Current resources

Website resources:
www.wahealthalliance.org/alliance-reports

- **2013 and 2014 Report**

- **County-level results**

Disparities in care: Upcoming activities

- **2015 Disparities in Care report:** Expected second quarter 2015

- **Upcoming Activities**
  - Semi-annual meetings for medical directors(includes confidential clinic-level reports)
  - Free webinars, based on interest, for groups working on regional improvement/health needs assessments(county-level reports)

Contact:

Teresa Litton, MPH, CPH
Performance Improvement
Washington Health Alliance
tlitton@wahealthalliance.org

Questions?