Data for Addressing Health Disparities

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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

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

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

Triple Aim
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High Value Care
2014 Disparities in Care report

Methods
Community Checkup and Disparities data process

Compiled and validated by Milliman USA

Medical groups update clinic rosters (via secure portal)

Measure results run

Patients attributed to providers (see attribution methods)

Medical group draft results prepared

Medical groups review draft results

Community Checkup measures reported by race, ethnicity and language

Final results published

Claims, enrollment and provider records from health plans, employers and union trusts

Feedback
Overview of data

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

Community Checkup Population Overview:
people enrolled any time during measurement year

Population included in Disparities of Care results

- 1.2 million
- 2.1 million

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

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

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

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

*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.
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.

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

*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.

<table>
<thead>
<tr>
<th>RACIAL/ETHNIC GROUP</th>
<th>CANCER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>BREAST</td>
</tr>
<tr>
<td>Medicaid* (All Enrollees)</td>
<td>45%</td>
</tr>
<tr>
<td>White</td>
<td>44%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>49%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>45%</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
<td>40%</td>
</tr>
<tr>
<td>Asian</td>
<td>56%</td>
</tr>
<tr>
<td>Native Hawaiian and Pacific Islander</td>
<td>46%</td>
</tr>
</tbody>
</table>

*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)
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Questions?