Aligning Forces for Quality
Equity and Disparities Webinar

December 17, 2008

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Growing U.S. Minority Population

Population Projections, 2008 to 2050

Percentage of Residents in AF4Q Communities who Speak a Language Other than English at Home (2000)

Puget Sound is defined as a 5-county area. King, Kitsap, Pierce, Snohomish, Thurston counties.

Willamette Valley, OR, is defined as a 5-county area. Benton, Lane, Linn, Marion, Multnomah counties. No LOE data for Benton, Linn counties.

West Michigan is defined as a 12-county area. Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Ottawa counties. No LOE data for Muskegon county.

Western New York is defined as an 8-county area. Allegany, Chautauqua, Cattaraugus, Erie, Genesee, Niagara, Orleans, Wyoming counties.

South Central Pennsylvania is defined as a 2-county area. Adams and York counties.

Source: US Census Bureau, State Quick Facts. Data are from 2000 Census.
What are disparities in health care quality?

• Racial or ethnic disparities are differences in the quality of health care received by members of different racial or ethnic groups that are not explained by other factors
  – Can occur at every stage in the continuum of care
  – Many possible causes and solutions

• Disparities in care represent a failure in quality
Institute of Medicine, 2002

Unequal Treatment

• “Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities”
• Less likely to receive recommended care:
  – Cancer treatment
  – Cardiac care
  – Kidney dialysis
  – Transplants
  – Curative surgery for lung cancer
  – Hip and knee replacement after OA
  – Pain medicines in the ED
Six Domains of Quality: Disparities Throughout

- Safety,
- Timeliness,
- Effectiveness,
- Efficiency,
- Equity,
- Patient-centeredness......STEEEP.

**Safety**: Asian or Pacific Islander and Hispanic nursing home residents are more likely to be physically restrained than other racial/ethnic groups.

Percentage of long-stay nursing home residents who were physically restrained, by race/ethnicity, July–September 2004.

![Bar chart showing percentage of restrained residents by race/ethnicity.](chart.png)

AI/AN = American Indian/Alaska Native.
Timeliness: Blacks are more likely than whites to leave the emergency department without being seen

Percent of emergency department visits in which the patient left without being seen, 1997-2004

Effectiveness: Minorities are less likely to have ever received a pneumococcal vaccination than whites

Percentage of adults age 65 and over who have ever had a pneumococcal vaccination, 2004

Note: Estimates are age adjusted to the 2000 U.S. standard population.
**Efficiency: Blacks with Medicare receive more end-of-life care than whites with Medicare.**

Percentage of Medicare beneficiaries admitted to intensive care unit in last six months of life, 1998–2001

![Bar chart showing percentage of Medicare beneficiaries admitted to intensive care unit](chart.png)

3.7 for White
4.1 for Black

Note: Data are age adjusted and correlations are weighted by the size of the black population.
**Patient-centeredness:** Blacks and Hispanics are less likely to report confidence and trust in their specialty physician than whites.

Percentage of patients reporting that they completely trusted their specialist physician, 1999–2000

Note: $p=.005$.

Why do disparities exist?

- Poor quality providers
  - Providers who care for minorities providing worse quality
- Regional variation
  - Minorities live in poor quality areas
- Bias and stereotyping
  - Probably not the biggest driver
In Sum…

• Disparities in care are real
• The reasons for disparities are very complex, but...it still means poor quality
• If everyone gets perfect care, there will be no disparities
• We need to know who our patients are to ensure they get quality care
We don’t know our patients

• Hospital, health plan, medical group data often does not include patient race or ethnicity, almost never language
• When present, data often incomplete and unreliable
  – Not a priority
  – Often from observation: “eyeballing”
• Most providers think that they provide high-quality care for all of their patients, but you will not know whether you provide quality care to all groups if you do not know who your patients are.
Question

What percent of hospitals that collect information on patient race and/or ethnicity use it for quality-related purposes?

a. More than 95 percent
b. About 80 percent
c. About 50 percent
d. Less than 25 percent

RACE and ETHNICITY: Officially two different things

• RACE
  – OMB 1997: white, black, Asian, Native Hawaiian or Other Pacific Islander (NHOPI), American Indian or Alaska Native (AI/AN)

• ETHNICITY
  – OMB 1997: Hispanic or Latino and not Hispanic or Latino
  – Can be much more granular (Iranian, Puerto Rican, Haitian, etc.)
An Equity Collaborative

• *Expecting Success:* Robert Wood Johnson Foundation-funded
  • Focused on evidence-based cardiac care for African-Americans and Latinos
    – AMI and heart failure
  • Major elements
    – Standardized collection of patient race/ethnicity/language data using **HRET Toolkit** (now **NQF** endorsed)
    – Rapid Cycle Improvement
    – Reported 23 quality measures on monthly basis by **patient race, ethnicity and language**
      • Core measures, all-or-none measures, CHF 30 day-readmission rate
Expecting Success Hospitals

- Duke University Hospital
  Durham, NC
- Mount Sinai Hospital
  Chicago, IL
- Sinai-Grace Hospital
  Detroit, MI
- Montefiore Medical Center
  New York, NY
- University of Mississippi Medical Center
  Jackson, MS
- Delta Regional Medical Center
  Greenville, MS
- Del Sol Medical Center
  El Paso, TX
- University Health System
  San Antonio, TX
- Memorial Regional Hospital
  Hollywood, FL
- Washington Hospital Center
  Washington, DC

Aligning Forces for Quality
Improving Health & Health Care in Communities Across America
Collecting accurate data on patient race, ethnicity and language

• No more “eyeballing”: Ask at registration
  – Change IS to capture data
• These hospitals now know who their patients are
  – One hospital’s experience with Spanish-speaking patients
• Lots of anxiety…but it was not that hard
Promoting Quality

- Three major improvement “themes”
  - Ensuring evidence-based care
    - Standard order use
  - Redesigned Processes
    - “Code Heart” to reduce PCI times
  - Discharge and transition
    - Heart Failure Educators
Hospital Y

Percent of Heart Failure Patients Receiving Discharge Instructions by Ethnicity

2005 Q4 - 2007 Q3

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<th>Year/Quarter</th>
<th>Hispanic Patients</th>
<th>Not Hispanic Patients</th>
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<tr>
<td>2007Q3</td>
<td>100%</td>
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</tbody>
</table>
Question

Among hospitals that collect race, ethnicity or language, what is the most commonly reported barrier to getting this information?

a. Confusion about race and ethnicity categories
b. Patient reluctance to provide the information
c. Staff reluctance to ask for the information
d. Perception that there are legal barriers to obtaining the information
e. Perception that there is no need for this information

The many uses of R/E/L data

With reliable R/E/L data, hospitals can:
• Provide person centered care
  – Interpreter services and educational materials
• Analyze service lines
  – Identify marketing opportunities
• Capture changes in hospital demographic trends
• Stratify quality measures
• Identify any disparities
Question

What percent of hospitals collect information on patient language?

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Resources:

*Expecting Success Toolkit*
www.rwjf.org/goto/expectingsuccesstoolkit

*HRET Disparities Toolkit*
www.hretdisparities.org/

*Speaking Together Toolkit*
www.rwjf.org/goto/speakingtogethertoolkit
National Health Plan Collaborative on Disparities (NHPC)

• **Members:** 11 of the nation’s largest HMOs with: **87 million total beneficiaries**
  - Aetna
  - BMC HealthNet
  - CIGNA
  - Harvard Pilgrim Health Care
  - HealthPartners
  - Highmark Inc.
  - Humana
  - Kaiser Permanente
  - Molina Healthcare
  - UnitedHealth Group
  - WellPoint, Inc.

• **Sponsors:** Agency for Healthcare Research and Quality (AHRQ) and the Robert Wood Johnson Foundation (RWJF)
• **Support Organizations:** CHCS, RAND, and GMMB
• **Evaluator:** Mathematica
NHPC’s Primary Goals

- Promote the collection of direct data on race, ethnicity and language
- Facilitate the provision of language access services
- Foster the systematic use of race, ethnicity, and language data for quality improvement
Data Collection Avenues Used by Health Plans

Primary sources
1. Member web portal or other member initiated contact
2. Member surveys
3. Encounter (office, hospital, etc.)
4. Enrollment
5. Health risk assessments
6. Disease management programs

Secondary sources
1. CMS (Medicare)/ State (Medicaid)
2. Employer

Indirect Data Collection Methods Used by Health Plans
1. Geocoding
2. Surname analysis
Sample Health Plan Activities

- Aetna has collected self-reported race/ethnicity and language data, primarily through its web portal, for over 5 million members (~30%). It develops quality improvement initiatives/pilots around areas that include chronic conditions, maternal and infant health, and medical interpretation.

- HealthPartners has collected race/ethnicity and language data for 30% of its members, primarily through its providers. It stratifies quality measures by race and ethnicity, develops quality improvement initiatives based on identified gaps in care, and shares information with its providers.

- Harvard Pilgrim is applying standards developed by the NHPC in assessing the quality of its translation and interpretation vendors.
Resource

The National Health Plan Collaborative Toolkit

http://www.rwjf.org/qualityequality/goto/NHPCToolkit
President-Elect’s Health Care Campaign Platform

Cites need to “challenge the medical system to eliminate inequities in health care by requiring hospitals and health plans to collect, analyze and report health care quality for disparity populations and holding them accountable for any differences found”
R/E/L Data Collection and the Law

• An increasing number of states mandate the collection and reporting of R/E/L data from certain providers or plans.
• Medicare will begin collecting quality data by race, ethnicity, and gender from providers within 2 years.¹
• It is legal to report de-identified data by R/E/L for quality improvement purposes.
• It is legal for providers and plans to collect this data in most circumstances.
  • Some states (CA, MD, NH, NJ, CT, MN, SD) prevent some types of insurance plans from collecting this data at the time of application for insurance coverage.

¹ Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Public Law 110-275, July 15, 2008
Future Events

- AF4Q Alliances will be focusing on issues of equity and disparities
- Stay tuned for:
  - Collaboratives on hospital disparities and language services (First quarter 2009)
  - Health Plan R/E/L data collection initiative (Second quarter 2009)
QUESTIONS?

Please type your question in the Q&A box located at the lower right-hand corner of your screen.