



*Aligning Forces for Quality
Equity and Disparities Webinar*

December 17, 2008

Bruce Siegel, M.D., M.P.H.

Director, *AF4Q* National Program Office

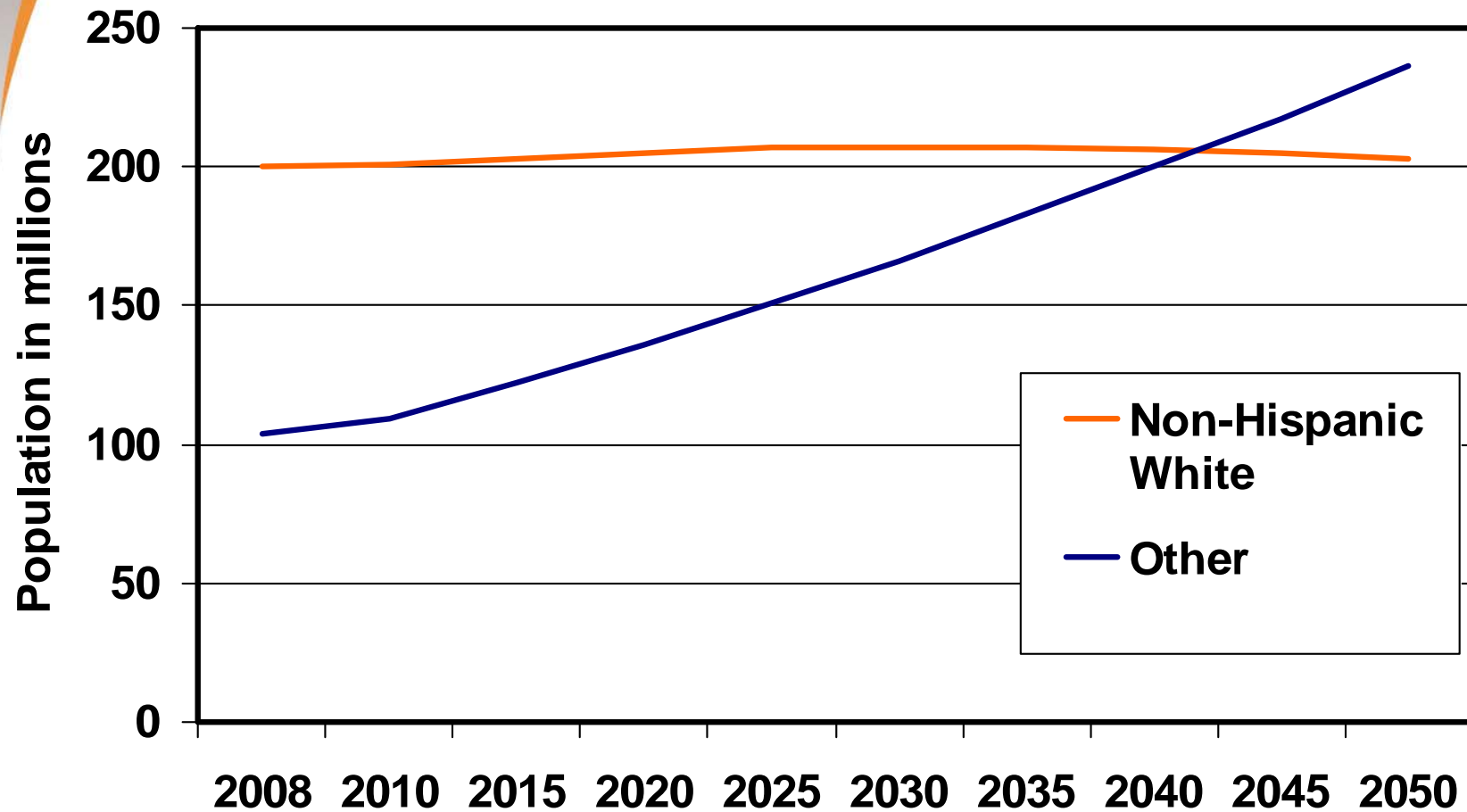
Center for Health Care Quality

The George Washington University Medical Center

School of Public Health and Health Services

Growing U.S. Minority Population

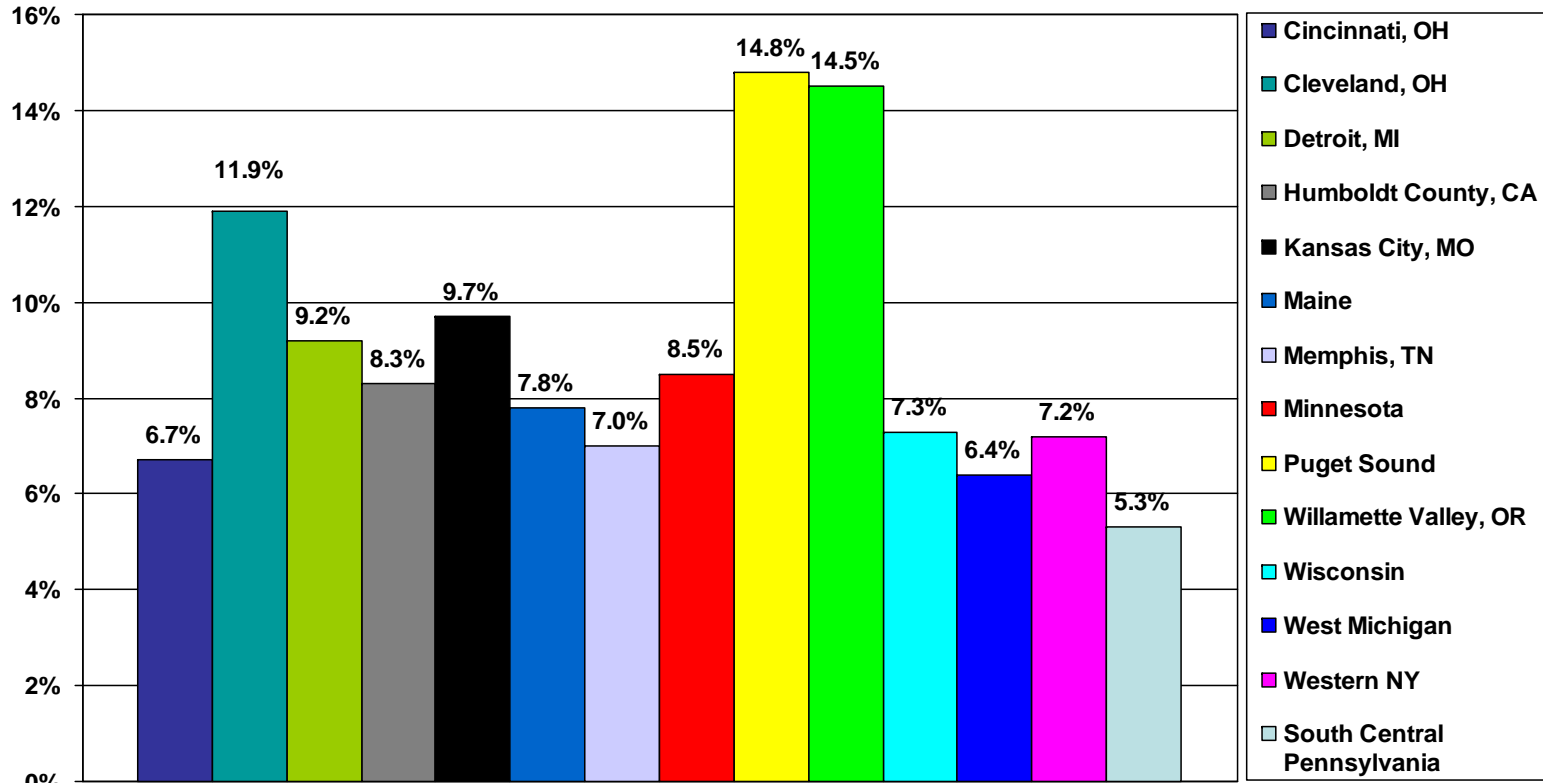
Population Projections, 2008 to 2050



Source: U.S. Census Bureau, "Projections of the Population by Race and Hispanic Origin for the U.S.: 2008 to 2050," *2008 National Population Projections Tables and Charts*, 2008.

**Aligning Forces
for Quality** | Improving Health & Health Care
in Communities Across America

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



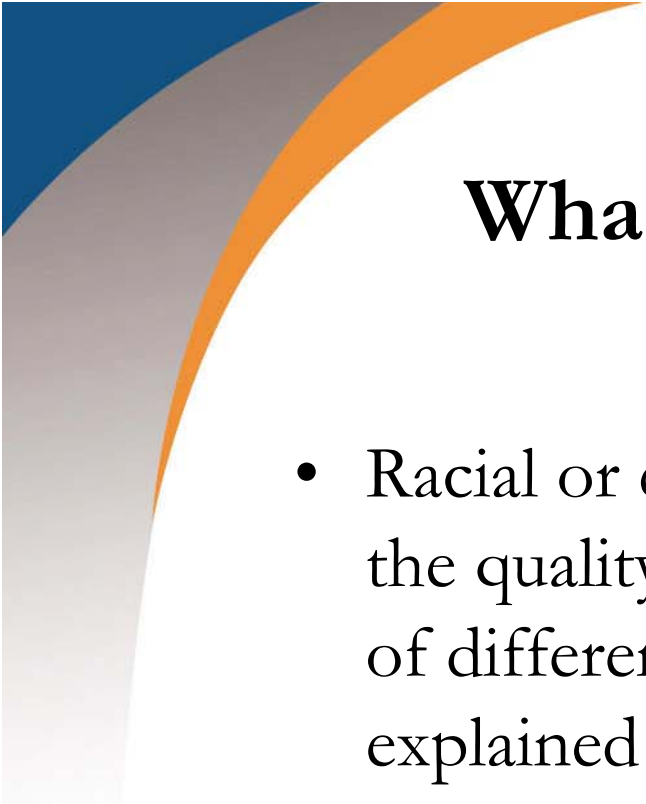
¹Puget Sound is defined as a 5-county area. King, Kitsap, Pierce, Snohomish, Thurston counties.

²Willamette Valley, OR, is defined as a 5-county area. Benton, Lane, Linn, Marion, Multnomah counties. No LOE data for Benton, Linn counties.

³West 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.

⁴Western New York is defined as an 8-county area. Allegany, Chautauqua, Cattaraugus, Erie, Genesee, Niagara, Orleans, Wyoming counties.

⁵South Central Pennsylvania is defined as a 2-county area. Adams and York counties.



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

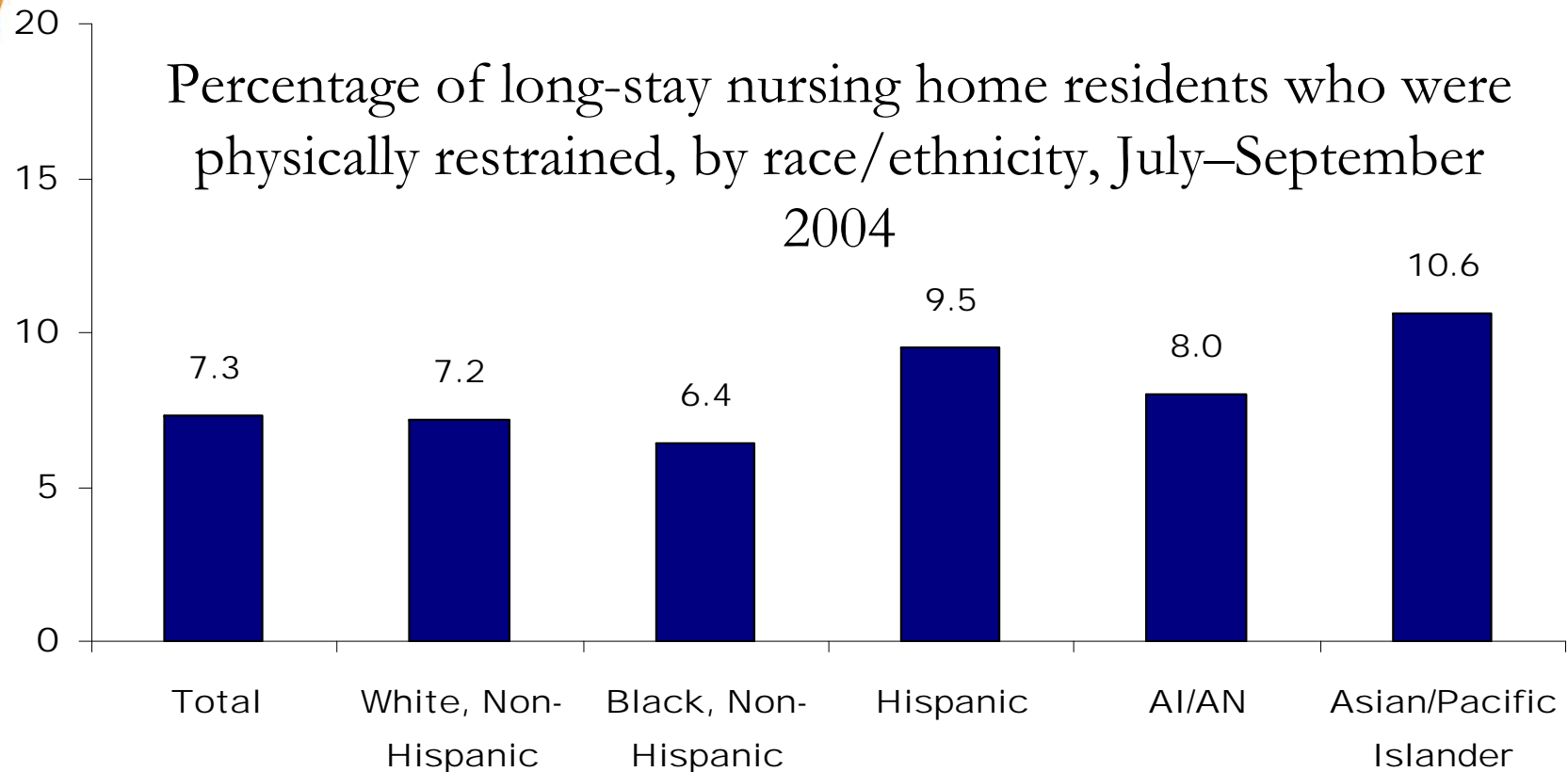


Six Domains of Quality: Disparities Throughout

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

From IOM, *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001.

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



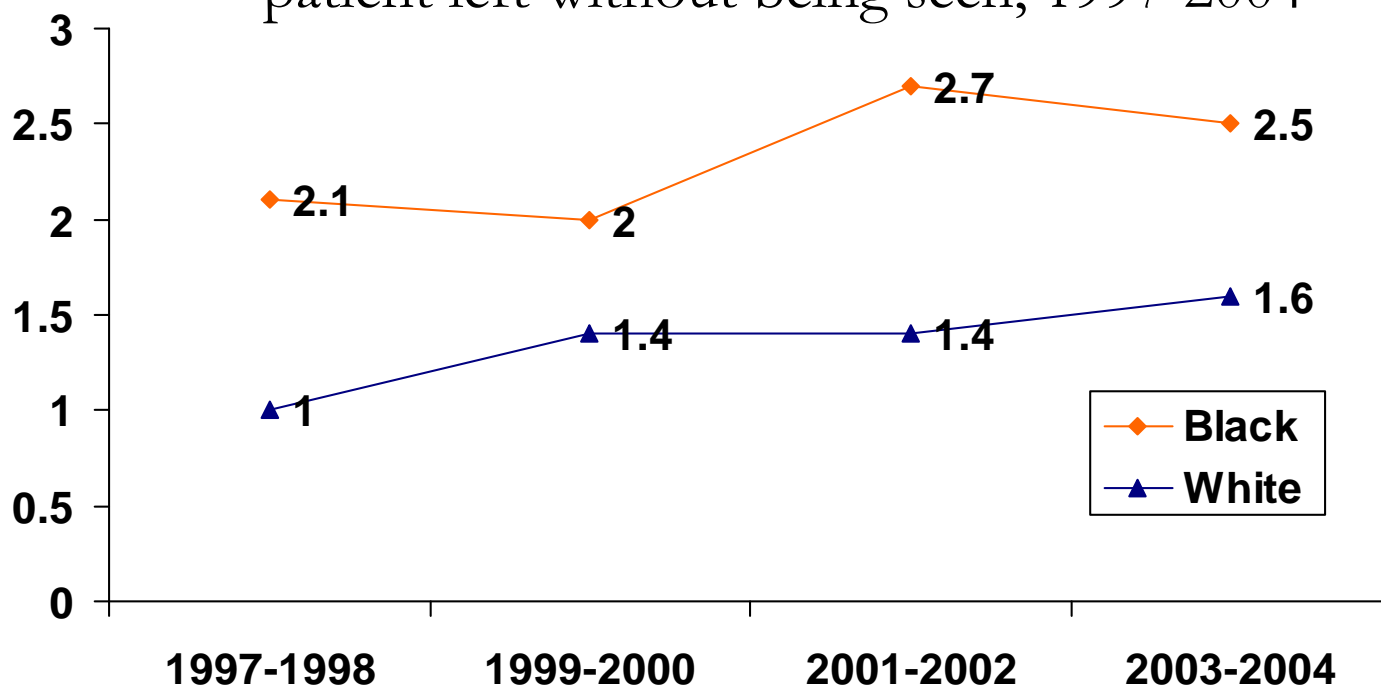
AI/AN = American Indian/Alaska Native.

Source: Agency for Healthcare Research and Quality.

National Healthcare Disparities Report. 2006.

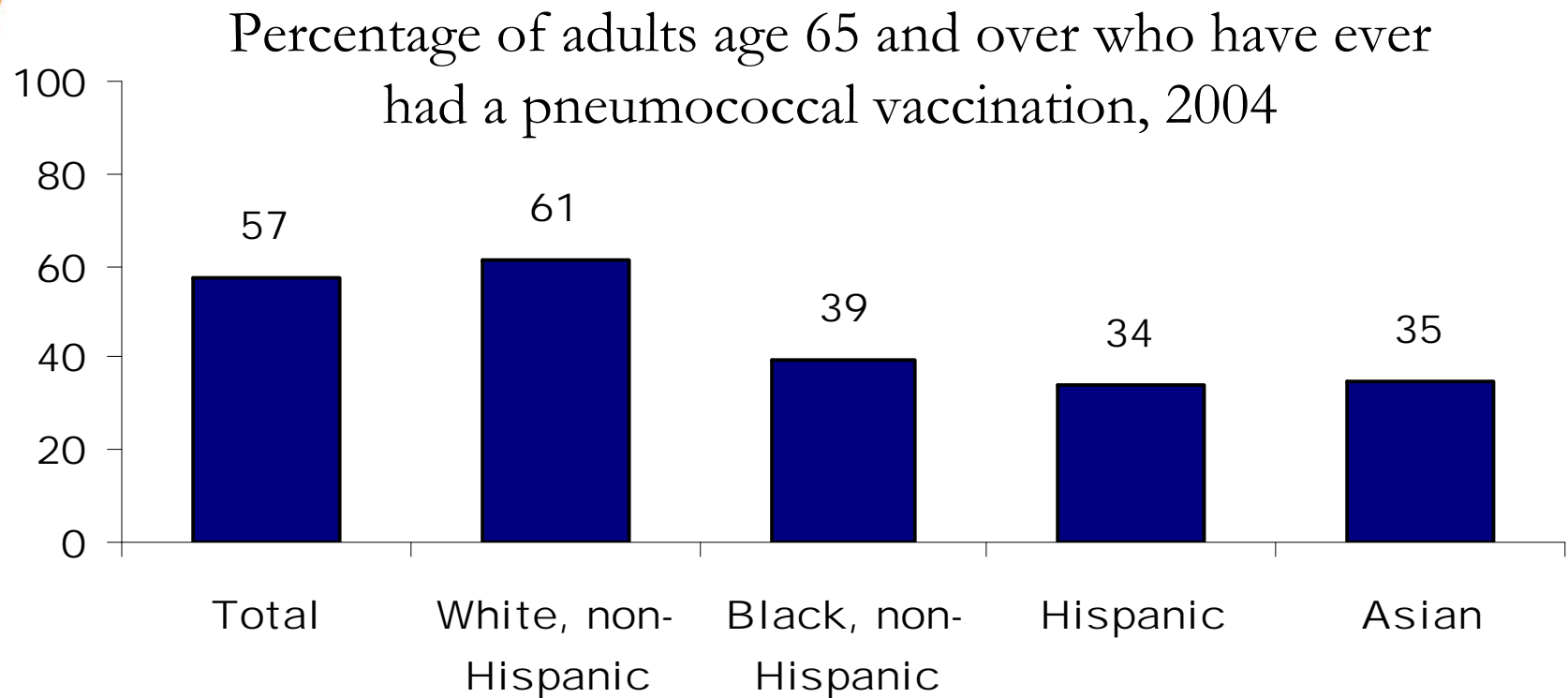
Timeliness: Blacks are more likely than whites to leave the emergency department without being seen

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



Source: Agency for Healthcare Research and Quality. *National Healthcare Disparities Report*. 2006.

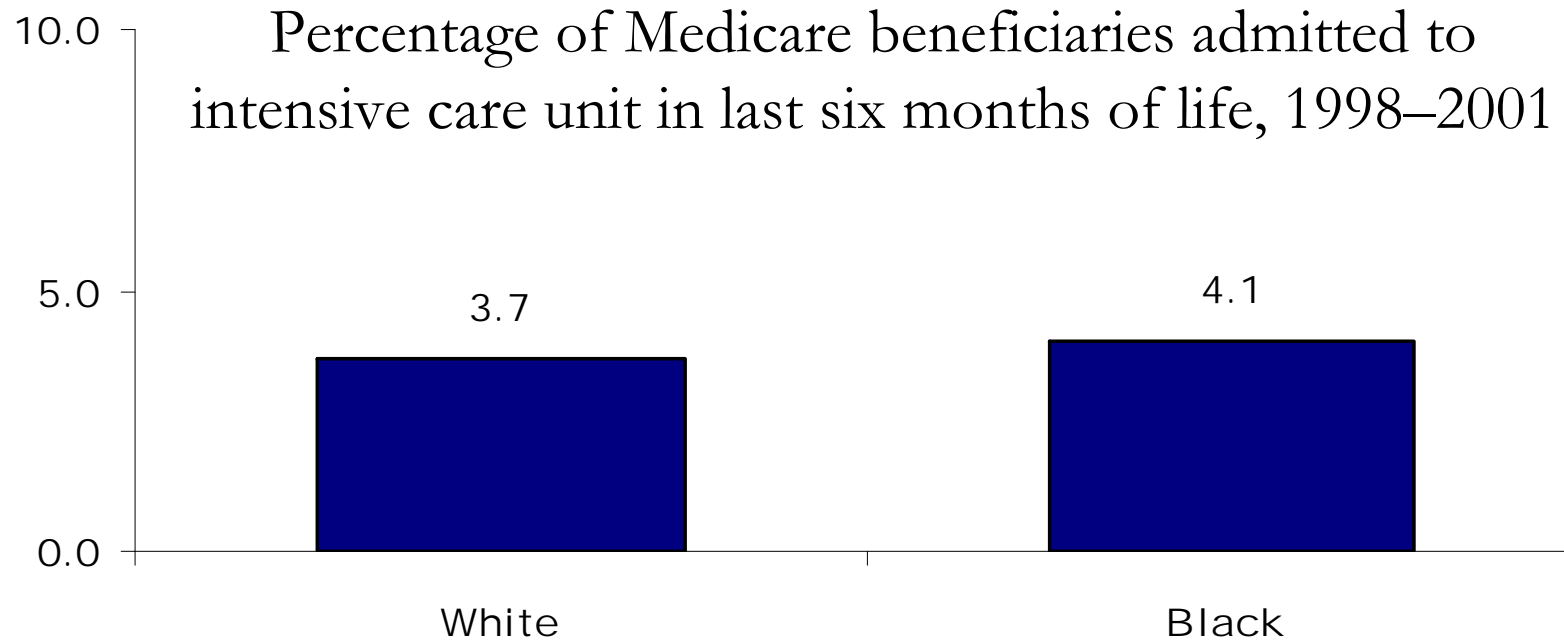
Effectiveness: Minorities are less likely to have ever received a pneumococcal vaccination than whites



Note: Estimates are age adjusted to the 2000 U.S. standard population.

Source: Agency for Healthcare Research and Quality. *National Healthcare Disparities Report*. 2006.

Efficiency: Blacks with Medicare receive more end-of-life care than whites with Medicare.

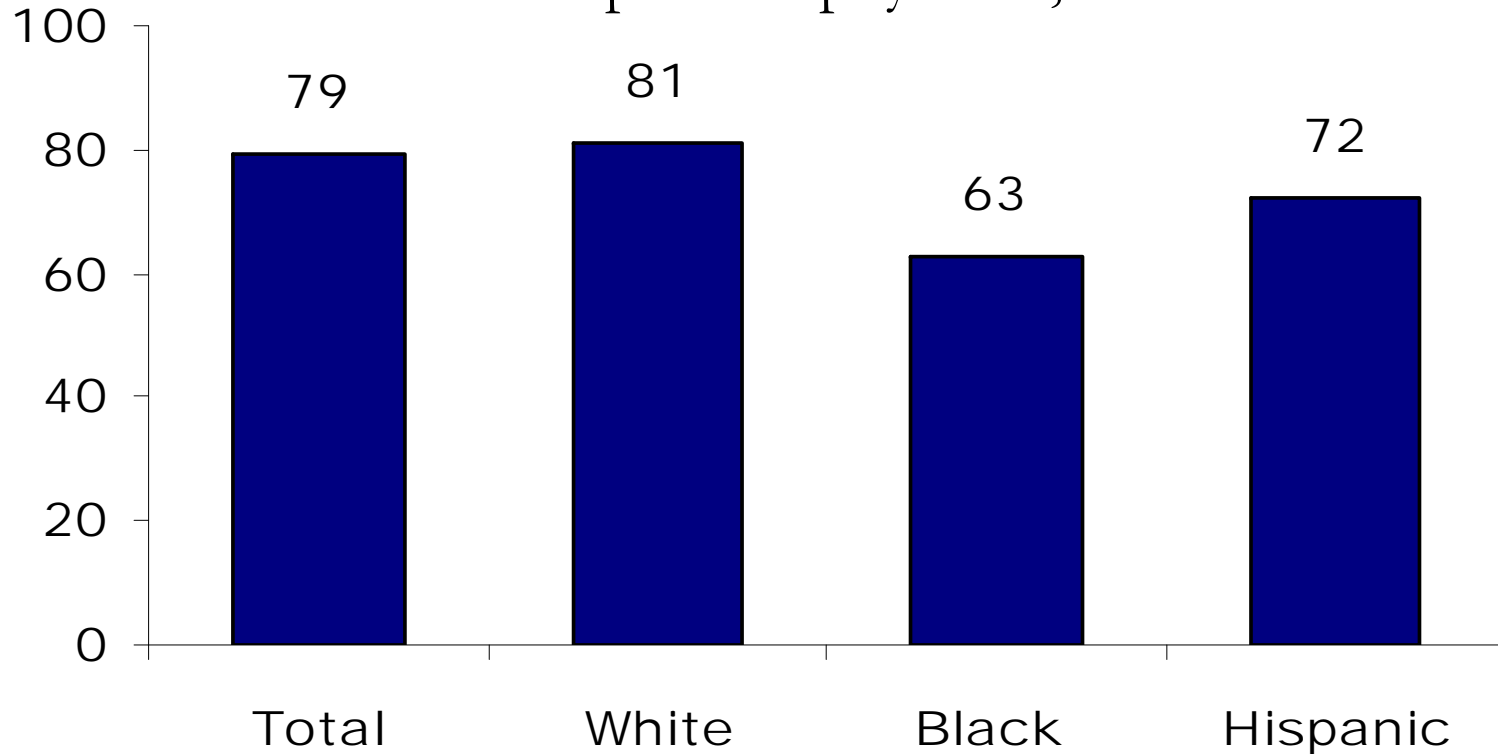


Note: Data are age adjusted and correlations are weighted by the size of the black population.

Source: K. Baicker et al., “Who You Are and Where You Live: How Race and Geography Affect the Treatment of Medicare Beneficiaries,” *Health Affairs* Web Exclusive (Oct. 7, 2004):var33–var44.

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: $p=.005$.

Source: N. L. Keating et al., "Patient Characteristics and Experiences Associated with Trust in Specialist Physicians," *Archives of Internal Medicine*, May 10, 2004 164(9):1015–20.



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

Source: Regenstein M, Sickler D, “Race Ethnicity, and Language of Patients: Hospital Practices Regarding Collection of Information to Address Disparities in Health Care,” National Public Health and Hospital Institute, 2006.



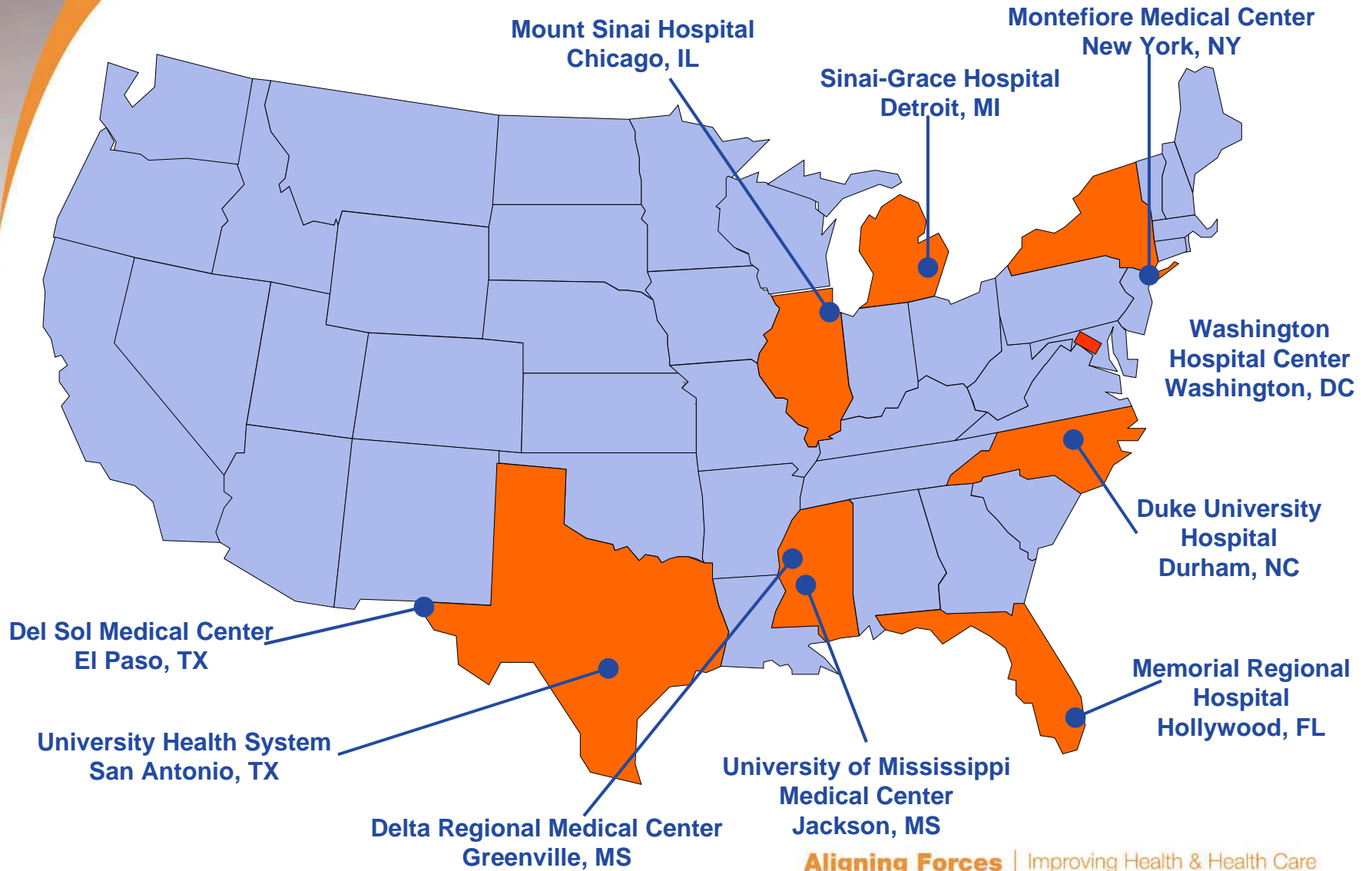
RACE and ETHNICITY: Officially two different things

- 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.)

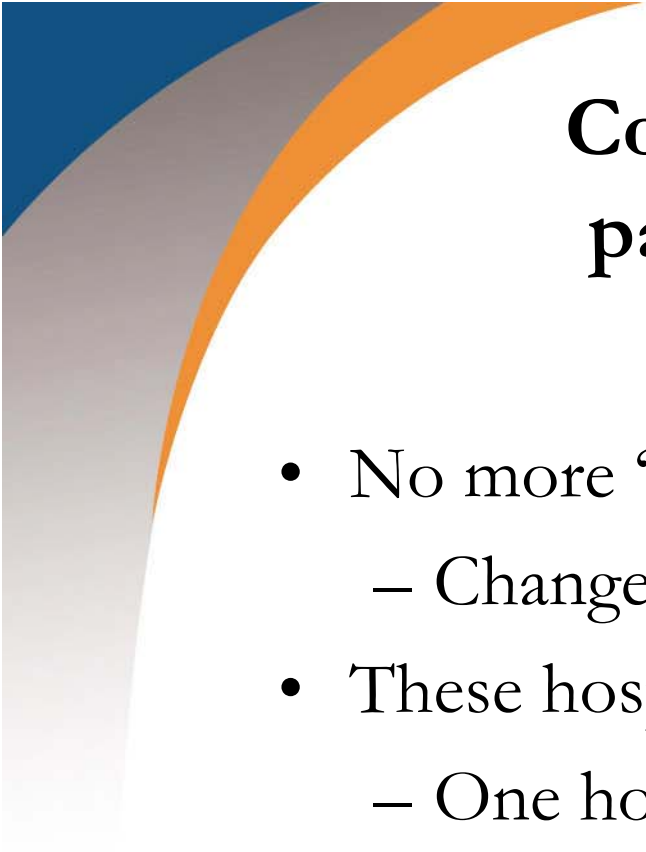
An Equity Collaborative

- *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



**Aligning Forces
for Quality** | Improving Health & Health Care
in Communities Across America



Collecting accurate data on patient race, ethnicity and language

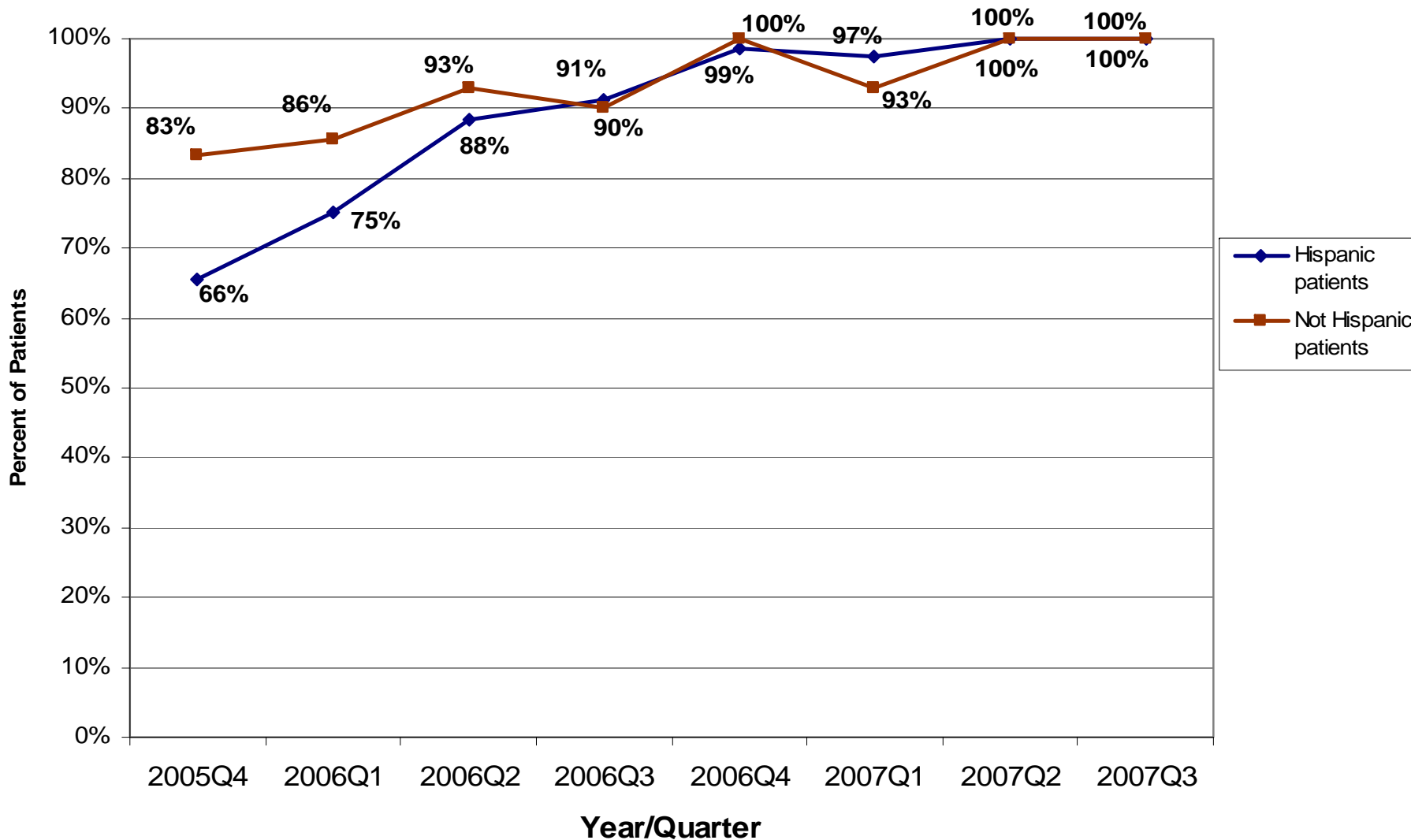
- No more “eyeballing”: Ask at registration
 - Change IS to capture data
- These hospitals now know who their patients are
 - One hospital’s experience with Spanish-speaking patients
- Lots of anxiety...but it was not that hard



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



We Ask Because We Care.

By asking about your race, ethnicity and language, we are better able to deliver health care equally to all patients.

What is your race?

What is your ethnicity?

What is your
primary language?



Respecting every difference, treating each equally.

GET REAL
Race, Ethnicity, and Language

Expecting Success:
Excellence in Cardiac Care
A national program of the
Robert Wood Johnson Foundation

Source: Chapter 6, *Expecting Success Toolkit*
www.rwjf.org/goto/expectingsuccesstoolkit

**Aligning Forces
for Quality** | Improving Health & Health Care
in Communities Across America



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

Source: Regenstein M, Sickler D, “Race Ethnicity, and Language of Patients: Hospital Practices Regarding Collection of Information to Address Disparities in Health Care,” National Public Health and Hospital Institute, 2006.



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?

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

Source: Regenstein M, Sickler D, “Race Ethnicity, and Language of Patients: Hospital Practices Regarding Collection of Information to Address Disparities in Health Care,” National Public Health and Hospital Institute, 2006.



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