Identifying and Reducing Disparities in Health Care

Lessons Learned From the Robert Wood Johnson Foundation

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

Robert Wood Johnson Foundation

Moderator

Susan Mende, BSN, MPH

Senior Program Officer

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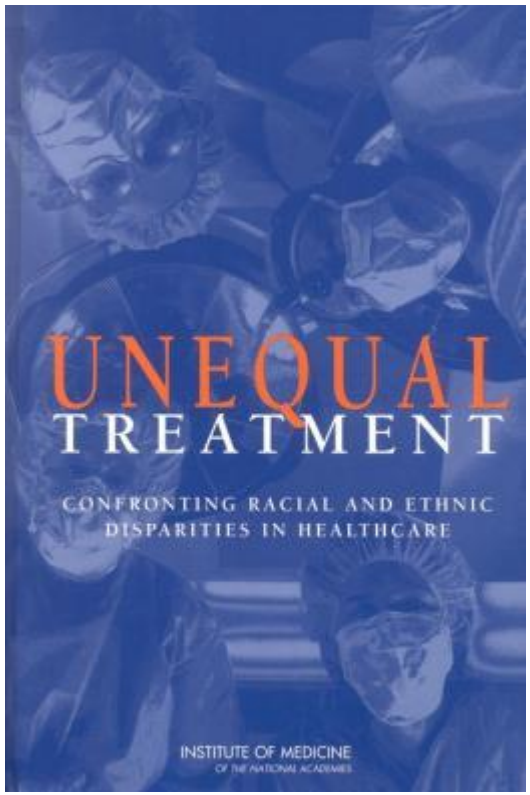
Disparities: An Age-Old Issue

Lyndon Johnson Signing Civil Rights Act, July 2, 1964

Stoughton, Cecil, White House Press Office (WHPO) – Public domain

Disparities: An Age-Old Issue



INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care

Released March 20, 2002

The Challenge

The quality of your health care depends on who you are.

40%

Blacks received worse care than Whites, and Hispanics received worse care than non-Hispanic Whites, for about 40 percent of quality measures.

33%

American Indians and Alaska Natives received worse care than Whites for one-third of quality measures.

25%

Asians received worse care than Whites for about one-quarter of quality measures, but better care than Whites for a similar proportion of quality measures.

Agency for Healthcare Research and Quality

2012 National Healthcare Disparities Report

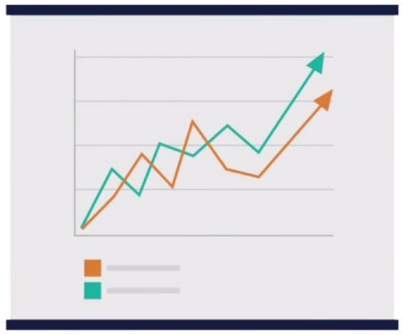
Lessons From the Field

- ***Aligning Forces for Quality*** (AF4Q) is the Robert Wood Johnson Foundation's signature effort to improve quality

- 16 communities across the country participate in AF4Q, bringing together the people who get care, give care and pay for care to improve quality

Lessons From the Field

Three key observations:



Reporting leads the way

It takes a (multi-stakeholder) village

Have patients at the table

Lessons from AF4Q: Cleveland

Thomas E. Love, PhD

Director, Data Center

Better Health *Greater* Cleveland

Professor of Medicine,
Epidemiology & Biostatistics

Case Western Reserve Univ.

Four Key Applications

- Communicating site, system, and regional case mix
- Regional disparities in achievement
- Regional disparities over time
- Members' only site
  - Comparing site-level achievement/trends by disparities subgroups
  - Comparing provider-level case mix

Describing the Region's Practices

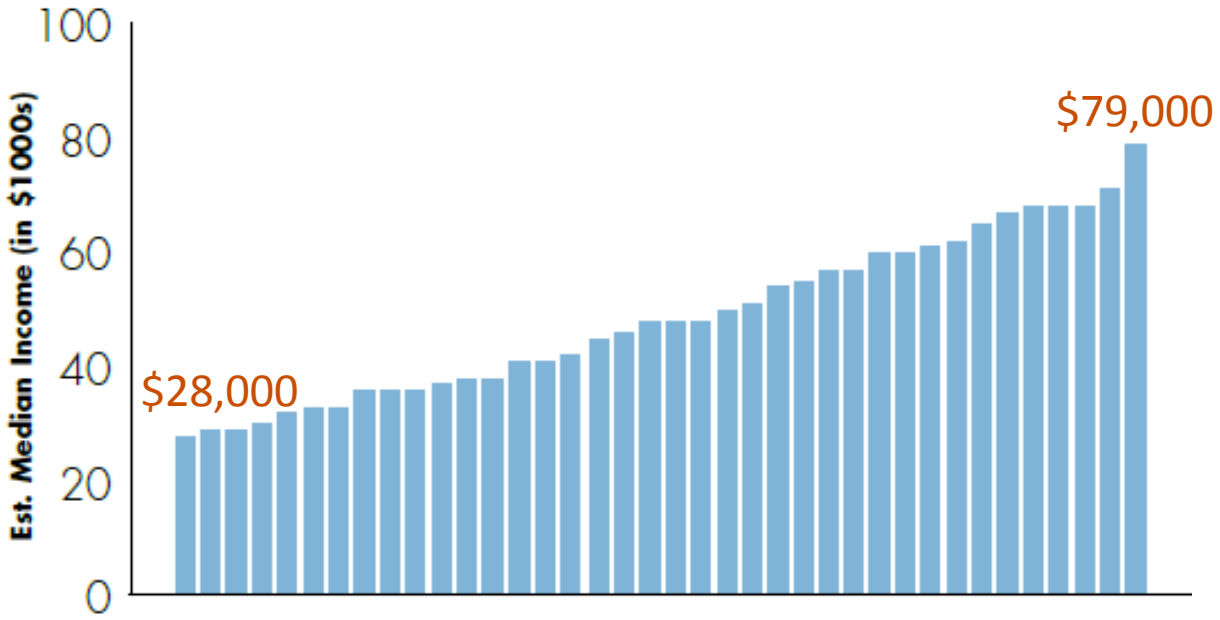


Figure 5. Estimated median income across diabetes patients, in thousands of dollars, via the American Community Survey. Each bar represents patients in one of our partner practices.

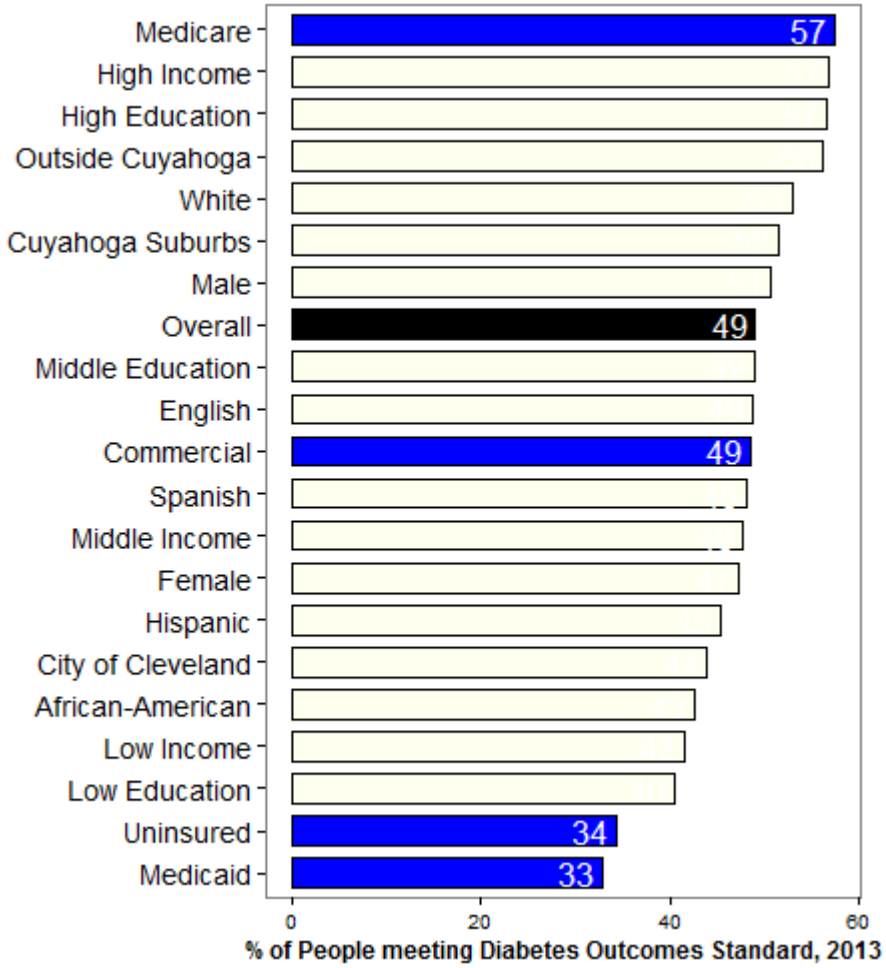
Estimates from American Community Survey; Special handling to avoid disclosure

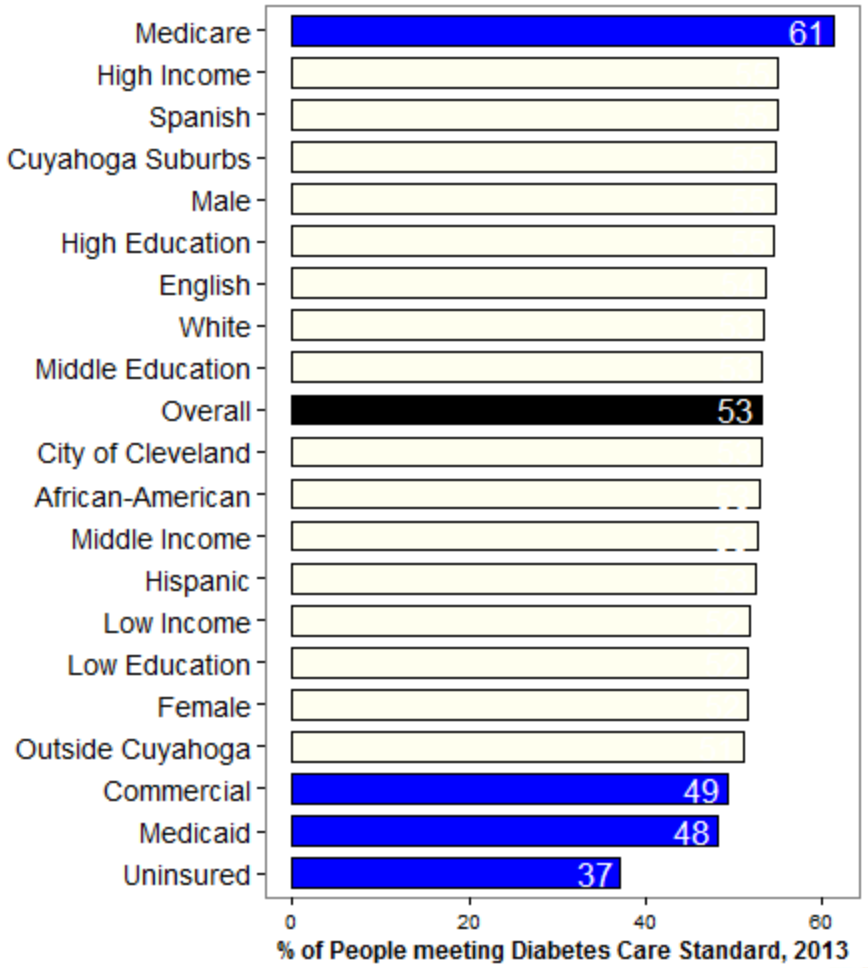
Our "Table 1"

- Condition
- EHR vs. Paper
- Insurance
- Race/Ethnicity
- Language
- Gender
- Est. Income and Educational Attainment
- Place of Residence

	Diabetes		High Blood Pressure		Heart Failure	
Health Systems	8		8		3	
Practice Sites	52		52		43	
Primary Care Physicians	656		711		460	
# of Qualifying Patients	34,820		134,421		6,627	
	Better Health Patients	Range Across Sites	Better Health Patients	Range Across Sites	Better Health Patients	Range Across Sites
By Insurance, %						
Medicare	40.0	2 - 77	45.6	3 - 84	73.0	45 - 91
Commercial	40.5	0 - 67	40.3	1 - 56	15.5	2 - 38
Medicaid	13.7	0 - 55	9.3	0 - 55	9.1	0 - 45
Uninsured	5.8	0 - 74	4.9	0 - 78	2.5	0 - 9
By Race /Ethnicity, %						
White	53.6	2 - 98	62.9	2 - 98	61.4	2 - 97
African-American	39.7	1 - 98	33.2	1 - 98	35.9	2 - 97
Hispanic	3.7	0 - 58	1.8	0 - 50	1.5	0 - 46
Other	3.1	0 - 75	2.2	0 - 73	1.2	0 - 3
By Preferred Language, %						
Language Documented	98.5	71 - 100	98.4	65 - 100	98.6	87 - 100
English	94.2	29 - 100	96.2	30 - 100	95.9	59 - 100
Spanish	3.1	0 - 56	1.6	0 - 47	1.7	0 - 41
Other Languages	2.6	0 - 71	2.2	0 - 70	2.4	0 - 9
Demographics						
Average Age	58.2	50 - 66	61.9	50 - 72	69.4	56 - 78
% Female	49.7	6 - 65	53.4	7 - 71	51.3	37 - 71
% in City of Cleveland	46.1	0 - 90	39.3	0 - 90	43.8	0 - 88
% in Cuyahoga County	77.6	0 - 100	73.4	1 - 100	77.3	1 - 100
Home Neighborhood Median Income ($1000s)	45.9	25 - 73	50.2	26 - 76	46.7	27 - 79
Home Neighborhood High School Grad. Rate, %	85.0	73 - 94	86.9	74 - 95	85.5	72 - 96
Population Health Measures, %						
Not Smoking	80.1	43 - 92	82.6	43 - 93	87.2	65 - 96
Blood Pressure in Control (BP < 140/90)	71.1	57 - 92	68.7	49 - 89	73.8	49 - 89
Weight in Control (Body-Mass Index < 30)	33.6	23 - 76	47.1	33 - 79	47.9	28 - 64

Diabetes Outcomes & Care (by subgroup, 2013)





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Members Only – Provider Case Mix

View Reports

Home > Select Reports > DEMO Practice Overview > **Physician Demographics for Diabetes**

Physician Demographics for Diabetes Patients in 2011

(DEMO Medical Center - DEMO Practice)

[Select a column to sort.]

Group	# Patients	Mean Age	Mean Income* (1000s)	Education HS Grad*	Female	White	African-American	Hispanic	Other Race	Medicare	Comm-ercial	Med-icaid	Unin-sured
1. Region	**30415**	**58**	**49**	**83**	**53**	**53**	**40**	**5**	**2**	**35**	**42**	**8**	**14**
2. DEMO System	**7402**	**56**	**36**	**75**	**61**	**37**	**48**	**12**	**3**	**34**	**20**	**22**	**25**
3. DEMO Practice	**611**	**54**	**30**	**66**	**58**	**22**	**13**	**63**	**1**	**34**	**13**	**29**	**24**
Physician 1	63	52	35	73	76	27	22	49	2	21	25	33	21
Physician 2	88	58	32	70	64	26	15	54	5	42	19	27	11
Physician 3	145	53	29	65	39	18	8	74	0	35	10	32	23
Physician 4	74	56	28	66	72	21	22	56	1	41	9	28	22
Physician 5	70	51	32	58	57	30	14	55	2	16	10	33	41
Physician 6	85	55	27	64	67	16	13	70	1	27	9	29	34
Physician 7	85	54	30	68	52	26	6	68	0	49	9	24	18

Diabetes data reflects providers with at least 25 qualifying diabetes patients.

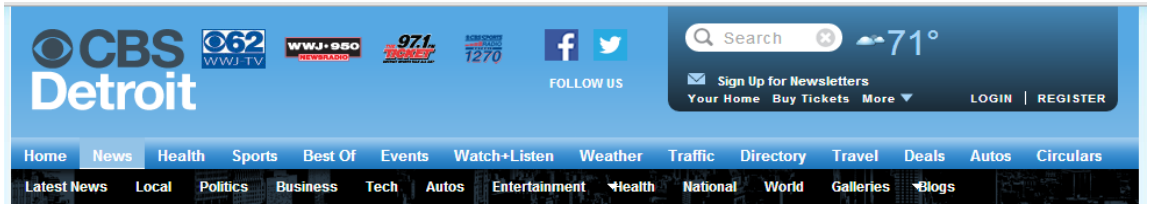
Lessons from AF4Q: Detroit

Cheryl Gibson Fountain, MD

Hypertension Intervention Project (HIP), Clinical Lead

Aligning Forces for Quality—Greater Detroit Area Health Council

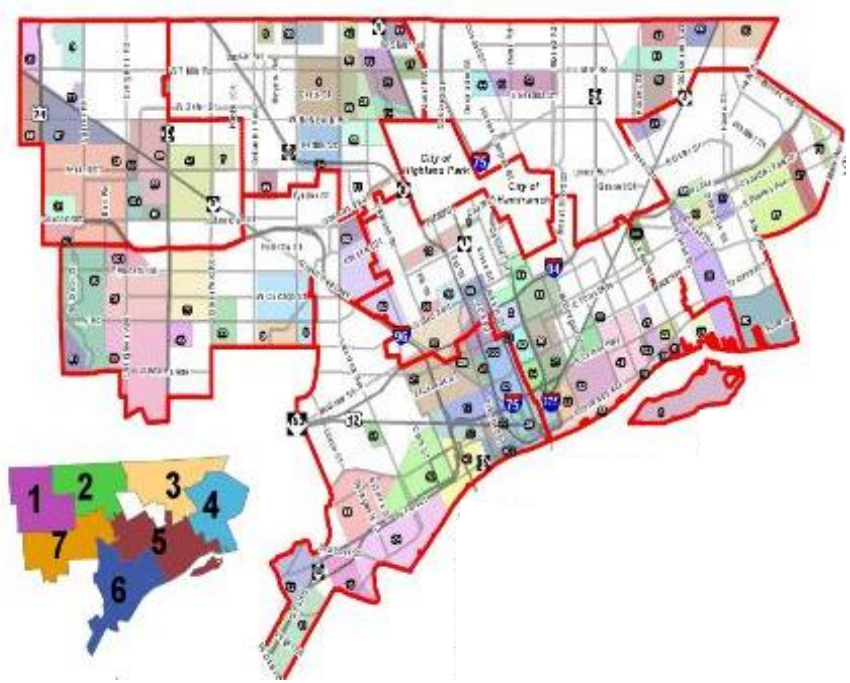
An Important Project



Local

Metro Detroit Ranks 2nd In 'Hypertension Hotspots'

1. Memphis, Tenn./Miss./Ark.
2. Detroit-Livonia-Dearborn, Mich.
3. Louisville-Jefferson County, Ky./Ind.
4. Birmingham-Hoover, Ala.
5. Dayton, Ohio
6. Pittsburgh, Pa.
7. Buffalo-Niagara Falls, N.Y.
8. St. Louis, Mo./Ill.
9. Oklahoma City, Okla.
10. Tampa-St. Petersburg-Clearwater, Fla.



http://detroit.cbslocal.com/2011/07/13/metro-detroit-ranks-2nd-in-hypertension-hotspots/

Hypertension Intervention Project

Peer-to-Peer Support for Blood Pressure Control

- Finding Answers, Disparities Research for Change model
- Patient is the star supplemented by physician education
- Patient takes the lead
- A focus on utilizing or advocating for local resources in patient's own community to improve health

Hypertension Intervention Project

Finding Answers Alabama Model:

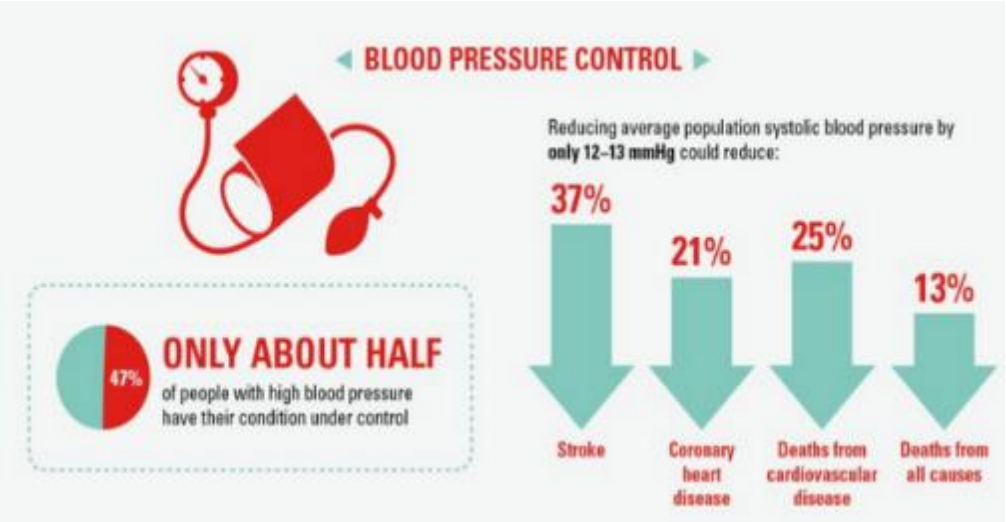
- Focus groups to identify our populations' needs, barriers, resources, and success stories
- "Star Participants"
- Video production (patient-focused supplemented by provider input)
- Recruitment
  - Physician referral
  - 300-350 patients
- Orientation sessions
- End-of-project session

Benefits of Patient-to-Patient Engagement

- Utilizing the power of personal storytelling to spark change
- Patient interaction and discussion
- Sharing information and problem-solving strategies among patients
- Emphasis on what is available in their own community to improve health

Our Hopes for the Project

- Relay new information on blood pressure and blood pressure control
- Continued patient interaction and discussion
- Sharing of informational resources
- Problem-solving among patients and doctors



- Emphasis on what is *really* available in their community to improve health
- The power to reduce high blood pressure in our community and improve overall health

Questions?

Select “Q&A” from the menu bar at the bottom of your screen:

Type in your question and it will be added the queue:

For More Information

- RWJF and AF4Q communities are continuing to work to reduce disparities in health care
- Resources mentioned in this webinar can be found at **www.rwjf.org/Equity**
- Continue the conversation on Twitter by using the hashtag #AF4Q