Identifying and Addressing Health Disparities

Minnesota Hospital Association Webinar
March 30, 2016
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Please turn off your computer speakers and dial into phone line (1-800-791-2345 code: 11076)
Today’s Agenda

1. Why It’s Important
2. Our Work to Reduce Disparity
3. Ideas for Future
<table>
<thead>
<tr>
<th>Health Plan</th>
<th>1.5 million members</th>
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</thead>
<tbody>
<tr>
<td>Medical Clinics</td>
<td>1,700 physicians</td>
</tr>
<tr>
<td></td>
<td>50 primary care locations</td>
</tr>
<tr>
<td></td>
<td>55+ medical specialties</td>
</tr>
<tr>
<td>Dental Clinics</td>
<td>60 dentists across 22 clinics</td>
</tr>
<tr>
<td></td>
<td>6 dental specialties</td>
</tr>
<tr>
<td>Hospitals</td>
<td>6 hospitals</td>
</tr>
<tr>
<td></td>
<td>Level 1 trauma and tertiary center</td>
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<tr>
<td></td>
<td>Acute care hospitals</td>
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<td>Critical access hospitals</td>
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- Consumer-governed, non-profit
- Integrated health and financing
- 22,500 team members
“The real challenge lies not in debating whether disparities exist, the evidence is overwhelming, but in developing and implementing strategies to reduce and eliminate them.”

Alan Nelson, MD
Chairman, IOM Committee
WHY IT’S IMPORTANT

Communities of color will grow faster than white population between 1995 and 2025.

- Hispanic origin: 248%
- African American: 113%
- Asian or Pacific Islander: 104%
- American Indian: 51%
- White: 8%

Source: State Demographic Center at Minnesota Planning
Life Expectancy in Twin Cities – △13 years

3 miles could equal up to a 13-year life span difference

70–75 YEARS

83+ YEARS

75–79 YEARS

83+ YEARS

70–75 YEARS

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A framework for why health disparities occur

Why Focus on Equity?

1. Racial and ethnic disparities in health care, and their root causes, have an impact on quality, safety, cost, and risk management.

   - Patients with limited-English proficiency:
     - suffer from more medical errors
     - have longer lengths of stay
     - may undergo more high-priced diagnostic tests
     - have higher rates of readmission

2. Addressing disparities is a current focus for the Joint Commission’s Accreditation Standards.
Equality doesn’t mean Equity
Equitable Care Work – HealthPartners

- Equitable Care Sponsor Group
- REaL Data
- Interpreter Services Work Group
- Ambulatory Care Equitable Care Efforts
- Regions Equitable Care Committee
- Equitable Care Champions
- Diversity and Inclusion efforts
HealthPartners Equitable Care Strategy

Reduce disparities with information & best clinical practices

Support language preferences

Partnerships and Engagement

Knowledge, Cultural Humility, Diversity & Inclusion

Community Members Patients
Cultural Competence

Ability to understand, appreciate, and interact with persons from cultures and/or belief systems other than one’s own.

(McGraw-Hill)

Knowledge and understanding of another person’s culture: adapting interventions and approaches to health care to the specific culture of the patient, family, and social group.

(Medical Dictionary for the Health Professions)
Cultural Humility

Life-long attitude and process

No power imbalance – each person brings something different

Partnership with people and groups
Community Partnership

Identify and engage community leaders

Patient Council

“It’s Time to Talk”

Learning Collaborative

Focus Groups
OUR IMPROVEMENT PROCESS

Obtain and Analyze data

Share data with key stakeholders

Develop and pilot test interventions

Disseminate best practice
Data Collection Process

1. Only need to ask once

2. Language and Interpreter needed during appointment scheduling

3. All patients asked Race/Ethnicity and Country of Origin during rooming
Improving Results
Used national data to decide where to start

Hospital Core Measures
➢ Process

Ambulatory
➢ Process and outcomes
  - Optimal diabetes care
  - Breast and colorectal cancer screening
  - Pediatric Immunizations
Perfect Heart Failure Care: Regions Hospital

Perfect Heart Failure Care By Race

Percent (%)

*Statistically significant difference (p<0.05)
Reducing the Gap: Race Breast Cancer Screening

GAP is 8.2% points

GAP is 4% points

HEDIS 2014 National 90th Percentile = 80.3%

80.3% 72.1%

85.4% 81.4%
Reducing the Gap: Socioeconomic Breast Cancer Screening

4th Qtr 2011
85.7% Commercial
69.3% MHCP

4th Qtr 2014
85.0% Commercial
74.5% MHCP

GAP is 16.4% points
HEDIS 2014 National 90th Percentile = 80.3%

GAP is 10.5% points

HealthPartners
Strategies to Reduce Disparities

Same Day Mammogram Registry Outreach
The “Pink Ticket” Program

Themes:
• Leadership
• Commitment
• Staff Passion
• Systems Approach
Integration of Disparities Reduction Goals in Accountability Mechanisms

- Data available by Clinic
- 90 day work plans to cascade awareness, goals and accountability
- Part of management incentive program
- Added to physician compensation program

<table>
<thead>
<tr>
<th>Location</th>
<th># white</th>
<th># of color</th>
<th>Point difference</th>
<th>% BC screening (all pts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic 1</td>
<td>278</td>
<td>48</td>
<td>-0.1</td>
<td>87.2%</td>
</tr>
<tr>
<td>Clinic 2</td>
<td>244</td>
<td>142</td>
<td>1.7</td>
<td>83.8%</td>
</tr>
<tr>
<td>Clinic 3</td>
<td>258</td>
<td>132</td>
<td>6.8</td>
<td>80.4%</td>
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**Monthly review:** Preview results at care meetings, Institute interventions, remind providers of goals, share best practice.
Building on our foundation
Regions Hospital

Available Data
Organizational Priorities
Engaged Leaders

National Data

➢ Hospital Readmissions
➢ Length of Stay – Excess Days
➢ Safety Measures
➢ Patient Satisfaction
What’s the data teaching us?

- Concentrated effort in the four strategy areas pays off.

- When we improve processes, we can improve care for all.

- We still have work to do.
The Birth Center Story

Birth Center

Home > Specialties > Birth Center

Schedule a tour
651-254-3580
+
Other helpful numbers

HealthPartners®
Patient Satisfaction in OB by Language

<table>
<thead>
<tr>
<th>Year</th>
<th>LEP</th>
<th>English</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>76.1%</td>
<td>84.2%</td>
</tr>
<tr>
<td>2014</td>
<td>79.0%</td>
<td>85.2%</td>
</tr>
<tr>
<td>2015</td>
<td>87.9%</td>
<td>88.9%</td>
</tr>
</tbody>
</table>
Patient Satisfaction by Language

<table>
<thead>
<tr>
<th>Year</th>
<th>Med Surg</th>
<th>OB Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>77.3 %</td>
<td>85.6 %</td>
</tr>
<tr>
<td>2014</td>
<td>74.5 %</td>
<td>82.6 %</td>
</tr>
<tr>
<td>2015</td>
<td>77.3 %</td>
<td></td>
</tr>
</tbody>
</table>

- English
- LEP

Upward trends and narrowing gaps in 2015
LOS by Language - Excess Days - MH

Significant disparity in MH by language

Full days
The Road Ahead

Spread best practices:
➢ Patient satisfaction by language in Med/Surg

Develop interventions:
➢ MH LOS by language

Continue Triple Aim focus:
➢ Language Preference and Health Literacy

Engage:
➢ Equitable Care Champions
Support Language Preferences
Promote Health Literacy

116 languages

Interpreter performance metrics

Teach-back methods

Language Top 4
1. Spanish
2. Somali
3. Hmong
4. Vietnamese
Equitable Care Champions

- Grassroots program of champions to support education, awareness at local level
- Over 120 Champions across the organization since 2003

“It has expanded my knowledge of and dedication to reducing disparities and working with other cultures.”
Barriers to Breast Cancer Screening Among Asian-American Women

By Sandy X. Jones

Scenario
A 54 year old Vietnamese woman, who has lived in the U.S. for 20 years, generally sees a doctor when she has an acute illness. She does not have a personal primary care physician and has not been to the clinic for nearly 2 years. At a recent visit, the nurse notified her that she was due for a mammogram and an annual physical including a pap smear (there is no documentation that she has ever had either completed before). The woman politely smiled at the nurse's comments but did not want to schedule any further exams.

Background
Did you know that when Asian women migrate to the U.S. their risk of receiving a breast cancer diagnosis increases up to six-fold? Although Asian American women have the lowest death rates for breast cancer of all racial/ethnic groups identified by the Centers for Disease Control, it is the most commonly diagnosed cancer for this population.

What are some of the factors affecting preventive screening rates in the population of Asian-American women?

Barriers to Screening
A number of cultural barriers—especially for older immigrants who grew up in an Asian homeland—may need to be addressed in order to increase mammography and other cancer screening rates in this population. Factors related to these barriers include:

- An Eastern vs. Western view of disease and treatment.
- Cultural practices around communication between authority figures (e.g. physicians) and 'common' people.
- Culturally-based feelings of physical modesty with regard to being viewed or touched (e.g., by a male physician).
- Potential concerns about stigma and shame associated with a cancer diagnosis.

As with any racial classification, there are multiple sub-groups of Asian women. Japanese women, for example, tend to have relatively high rates of cancer screenings, including mammography. Hmong and Korean women are among the least-screened of this group.

Recommendations for Caregivers
An Ethnomed.org article on breast cancer in Asian-American women recounted the findings of a Vietnamese women's focus group on the topic (see link below). Education of women is key. Recommendations, based on these findings, include:

1. Non-English-speaking (less acculturated) and especially older women may not know what breast cancer screening or mammography is. The actual equipment and process may need to be explained;
2. Women need to know that breast cancer may not cause any pain or other symptoms until it is at a very advanced stage;
3. Because, like most cancers, breast cancer is much more difficult to treat at advanced stages, it is much safer to not solely pursue traditional or folk remedies before seeking medical care. Being open to talking with a patient about simultaneously pursuing traditional Eastern and Western medical approaches may increase trust with an older Asian woman;
4. Studies have found that a direct conversation with a medical provider are likely to be more powerful than a mailing or advertising regarding screening recommendations. But even in conversation, remember that smiling and nodding may simply be a sign of respect and not necessarily reflect understanding and/or agreement.

For More Information
American Cancer Society: Guidelines for the Early Detection of Cancer

Ethnomed: Breast Cancer in Asian Women
http://ethnomed.org/clinical/cancer/breast-cancer-in-asian-women

Minority Women's Health: Breast Cancer

Susan G. Komen for the Cure
http://ww5.komen.org/uploadedFiles/Content_Binaries/806-373a.pdf
Questions?

Câu hỏi?

Su'aalo?

¿Preguntas?

 أسئلة؟

有問題嗎？

Pertanyaan?