Trajectories

Aim Toward Outcomes

NOVEMBER 2015 ■ DISPARITIES IN HEALTH CARE QUALITY

Trajectories is a bimonthly publication highlighting Missouri hospital initiatives to improve the health of their communities, as well as the experience and effectiveness of the care provided to their patients.

"Achieving health care equity and eliminating health care disparities are top goals of hospitals and health systems. Health care equity has become an important discussion nationally as policymakers aim to improve quality of care while lowering costs through a variety of changes to existing incentives. The United States is becoming more diverse demographically, with racial and ethnic minorities projected to become the majority of the U.S. population by 2042. Nearly 47 million people speak a language other than English at home."[i]

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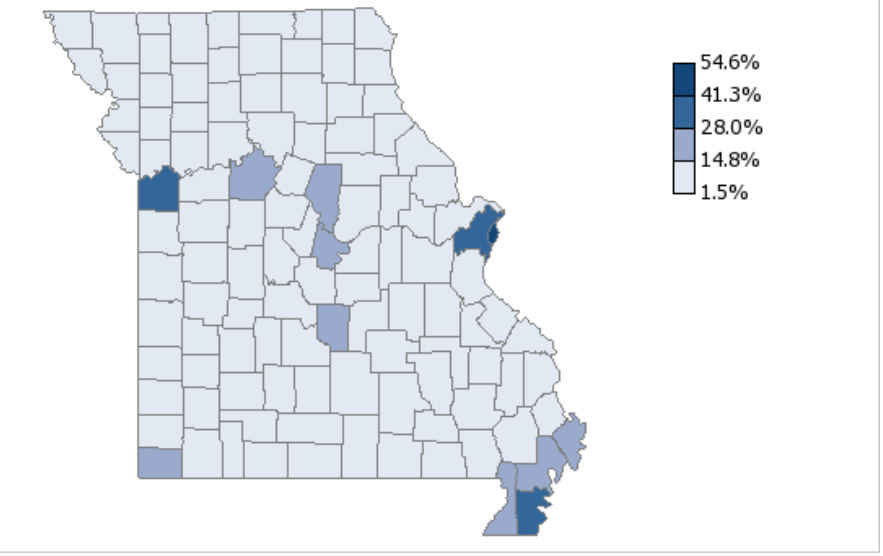
Despite minor improvements, there is evidence that national health care systems are not meeting the ever-changing needs of the communities they serve. Research shows that disparities in health care can lead to increased medical errors, prolonged length of stays, avoidable hospitalizations and readmissions, and over- or under-utilization of procedures.[i] To achieve their goals of creating a society of healthy communities and to support hospitals' efforts to improve quality and health care equity in communities, the American Hospital Association released "Equity of Care: A Toolkit for Eliminating Health Care Disparities." This toolkit is a major national collaborative to increase the collection and use of race, ethnicity and language data, cultural competency training, and diversity in governance and leadership.[i]

Hospitals across Missouri are facing and addressing those same national challenges. Specific work, including use of AHA's equity of care toolkit, is explained under Missouri's approach on page 3. Many of the association-led quality improvement projects, such as the Hospital Engagement Network 2.0 and the Missouri Hospital Association transparency initiative, encourage hospitals to identify the social determinants of health the patients in their communities are facing and eliminate health care disparities.

Measures in the national pay-for-performance programs aim to mitigate the impact of social determinants of health in the diverse population of patients that hospitals treat, while stabilizing distribution of payment for those services.

Figure 1: 2015 Minority Population for Missouri Counties



Source: Hospital Industry Data Institute, 2015.

Social determinants of health are the conditions in which people are born, where they live and work, and their age. Social determinants of health are mostly responsible for health inequities — the unfair and avoidable differences in health status seen within and between areas.[ii] Select measures in the Centers for Medicare & Medicaid Services' Value-Based Purchasing program are risk-adjusted based on certain disparate factors. Specifically, mortality outcomes are adjusted for age, gender and comorbidities. The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) are adjusted based on factors related to diversity, including primary language, education and age.

Disparities in Missouri

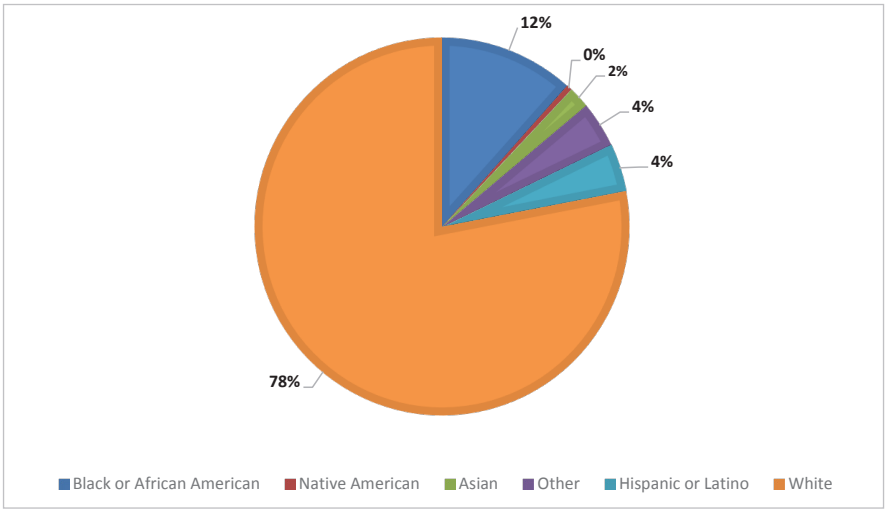
The minority population in Missouri is growing. In 2015, Jackson, St. Louis, and Pemiscot Counties have the highest percentage of minority populations between 28 and 41.3 percent.

The African American or black population in Missouri has increased by almost 85,000 since 2000, a change of 13.1 percent. In contrast, the white population increased 5.3 percent during the same period.[iii] To reflect this population shift, it is increasingly important for health care providers to identify and reduce racial and ethnic disparities in their care.

Figures 3 through 8 represent analyses of several chronic conditions in Missouri. There are obvious disparities in the outcomes noted between populations as they relate to admissions for the specified conditions. These measures were evaluated as part of MHA's transparency initiative, which is a two-phased approach to public reporting of a set of specific quality outcome measures.

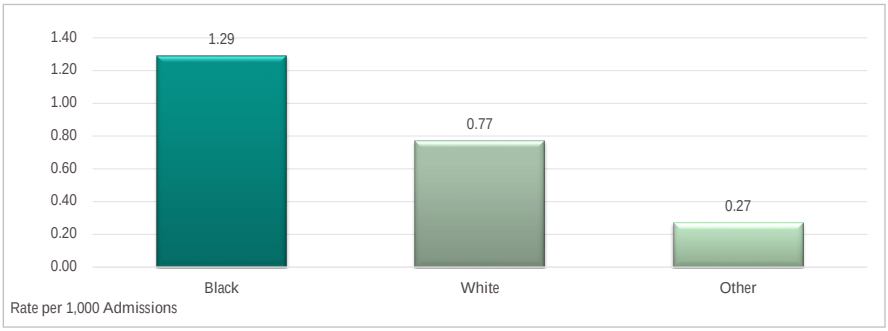
When compared side by side, white and non-white populations in Missouri also show differences in

Figure 2: Missouri Population by Race and Ethnicity, 2015



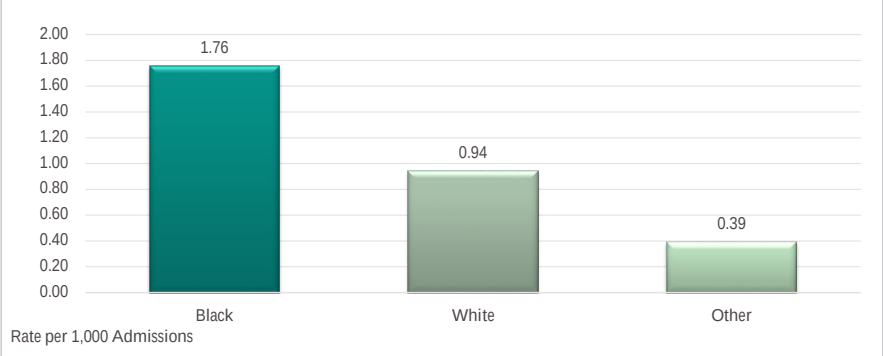
Source: Nielsen-Claritas, 2015.

Figure 3: Diabetes Short-Term Complications Admission Rate by Race, Federal Fiscal Year 2014



Source: Hospital Industry Data Institute, 2015. The Agency for Healthcare Research and Quality's Patient Quality Indicator.

Figure 4: Diabetes Long-Term Complications Admission Rate by Race, FFY 2014



Source: Hospital Industry Data Institute, 2015. The Agency for Healthcare Research and Quality's Patient Quality Indicator.

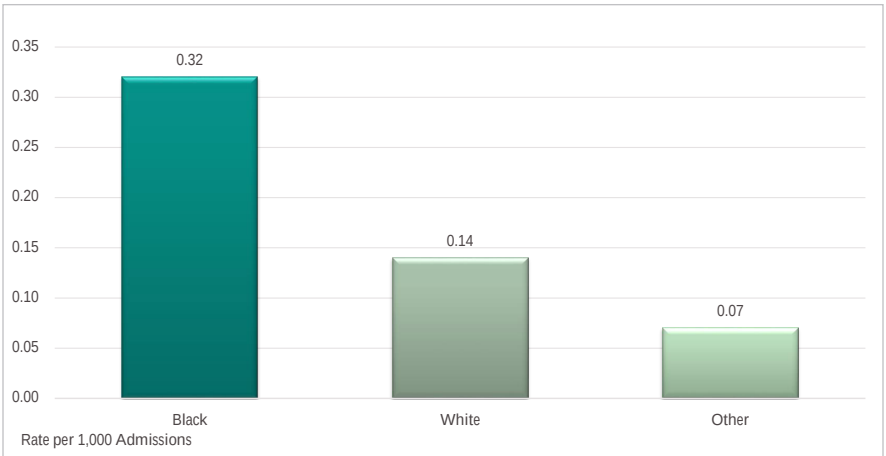
outcomes for several health care indicators, as specified by age categories. The non-white population showed higher rates for hospitalwide readmission, acute myocardial infarction readmission, methicillin resistant staphylococcus aureus and *C-difficile*. The admission, readmission and harm data indicate that Missouri hospitals need to assess the health status, outcomes, behaviors and possible exposures for those identified populations and identify strategies to address gaps. These measures, under MHA's transparency initiative, will be analyzed quarterly and used as a resource to target improvement strategies that drive the reduction in disparities in both readmissions and patient harm in all Missouri hospitals.

Missouri's Approach

MHA's approach to addressing disparities in health care includes work in the HEN 2.0, the transparency initiative and adaptive support to hospitals with their community health needs assessments.

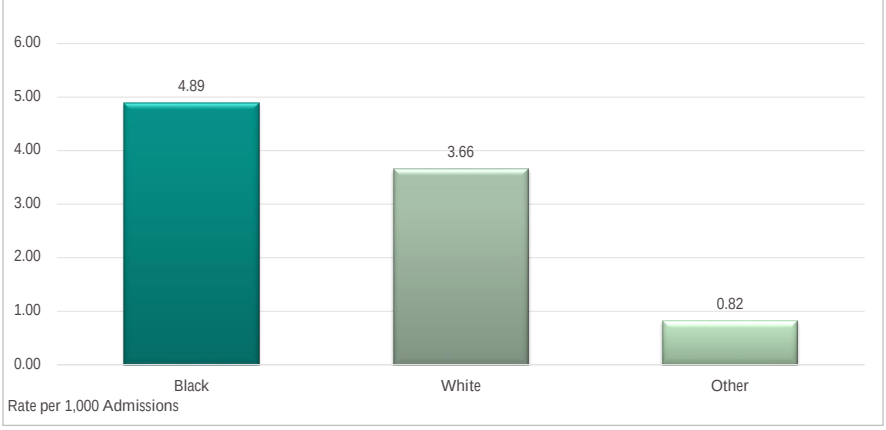
Through the national work of HEN 2.0, MHA will track and address health care disparities while engaging in activities to reduce identified inequalities. National resources, such as the "Equity of Care: A Toolkit for Eliminating Health Care Disparities," will be used to educate participating hospitals about the importance of proper data collection, explain how to implement a framework to collect the race, ethnicity, age and language data in their organization, and identify areas of improvement in patient health outcomes. Disparities will be regularly analyzed to provide guidance for statewide readmission and patient harm education and resources. Hospitals will be encouraged to use this information when approaching a process improvement project or conducting CHNAs.

Figure 5: Uncontrolled Diabetes Admission Rate by Race, FFY 2014



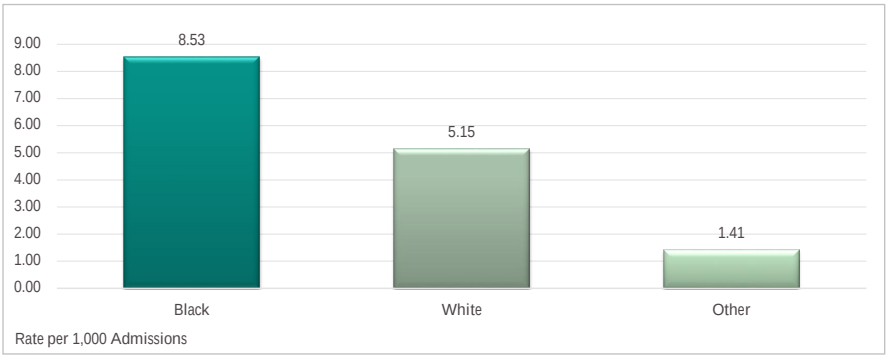
Source: Hospital Industry Data Institute, 2015. The Agency for Healthcare Research and Quality's Patient Quality Indicator.

Figure 6: Heart Failure Admission Rate by Race, FFY 2014



Source: Hospital Industry Data Institute, 2015. The Agency for Healthcare Research and Quality's Patient Quality Indicator.

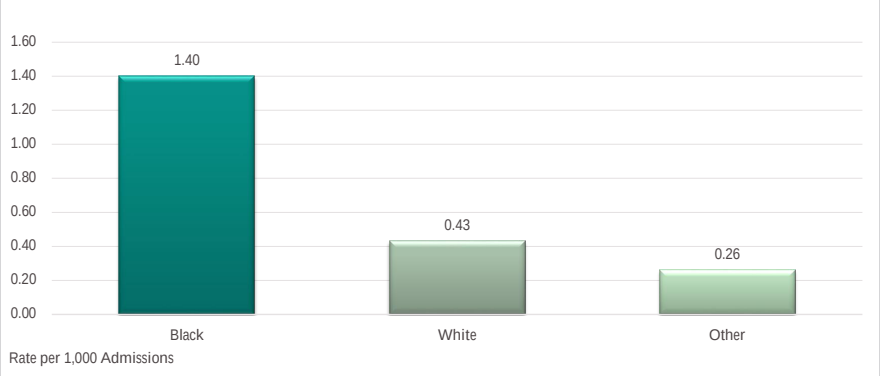
Figure 7: COPD or Asthma Complications Admission Rate by Race, FFY 2014



Source: Hospital Industry Data Institute, 2015. The Agency for Healthcare Research and Quality's Patient Quality Indicator.

Identifying and reducing disparities throughout Missouri will be a priority of MHA's transparency initiative. The goals of the initiative include reducing variation in the care provided among Missouri hospitals and providing accurate information to consumers. Quality measures are analyzed every quarter to assess the potential and/or existing disparities present in Missouri. Findings and national resources, such as the "2014 National Healthcare Quality and Disparities Report," will be used to develop and drive statewide strategy and education to facilitate increased focus and improvement through the use of toolkits, resource sharing and webinars.

Figure 8: Hypertension Admission Rate by Race, FFY 2014



Source: Hospital Industry Data Institute, 2015. The Agency for Healthcare Research and Quality's Patient Quality Indicator.

The Centers for Disease Control and Prevention has found that mortality and morbidity factors disproportionately affect certain populations, which require the implementation of strategies aimed at identifying and creating awareness among diverse populations.

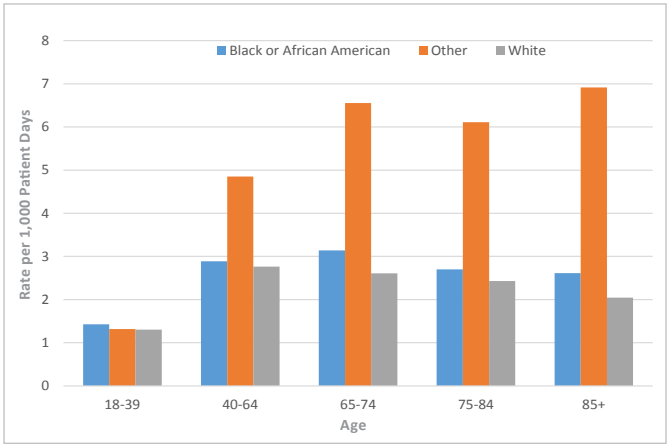
Disparities were examined for characteristics that included race and ethnicity, sex, age, household income, educational attainment, and geographic location. The CDC also analyzed data that included birth place, language spoken at home, disability status and sexual orientation. Analysis focused on the estimated prevalence of risk factors or health outcomes or on the estimated rate of health outcomes in the population.

The CDC identified the need to monitor health status, outcomes, behaviors and exposure by population groups to assess trends and target interventions. Disparities were found across race and ethnicity for all the health topics reviewed during this study. The survey also revealed that people of low socioeconomic status were more likely to be affected by certain chronic diseases, such as diabetes, hypertension and human immunodeficiency virus infection. In addition, they were less likely to be screened for colorectal cancer.

Despite persistent racial, ethnic and socioeconomic gaps in health care and health status, awareness of such disparities remains low among the public. Much can be accomplished within the health and public health arena; however, the complex web of health disparity causes can only be fully addressed with the involvement of many partners in fields that influence health such as housing, transportation, education and business.

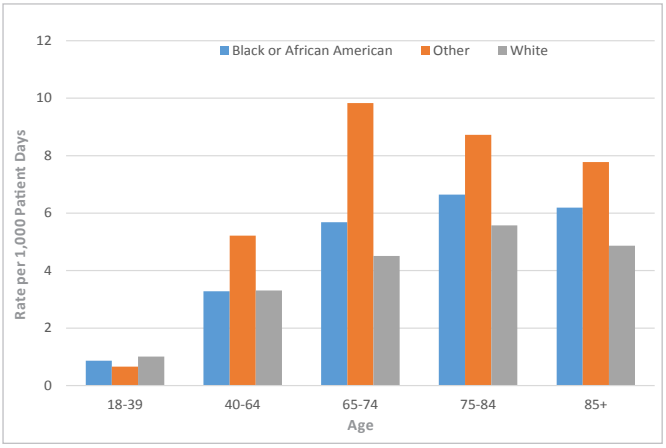
Identifying disparities and monitoring them throughout time is a necessary first step toward the development and evaluation of evidence-based interventions that can reduce disparities. The information can be used by practitioners in public health, academia and clinical medicine, the media, patients and families, policymakers, program managers and researchers to address disparities and help everyone in the U.S. live longer, healthier and more productive lives.[iv, v]

Figure 9: MRSA by Race (2013-2015)



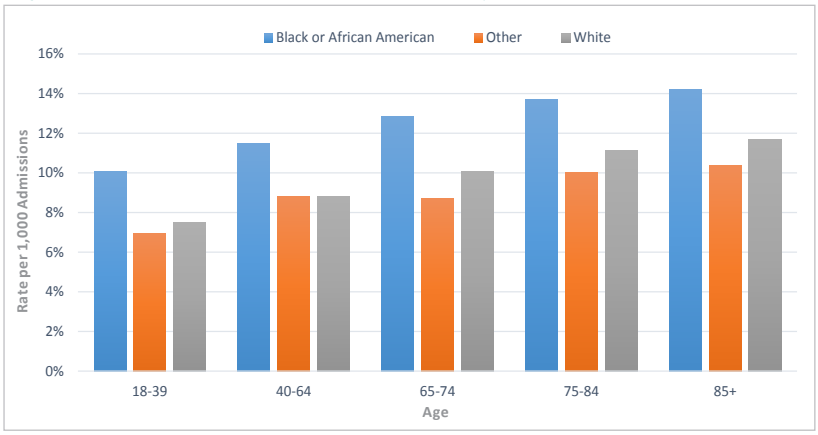
Source: Hospital Industry Data Institute, 2015.

Figure 10: *C. difficile* by Race (2013-2015)



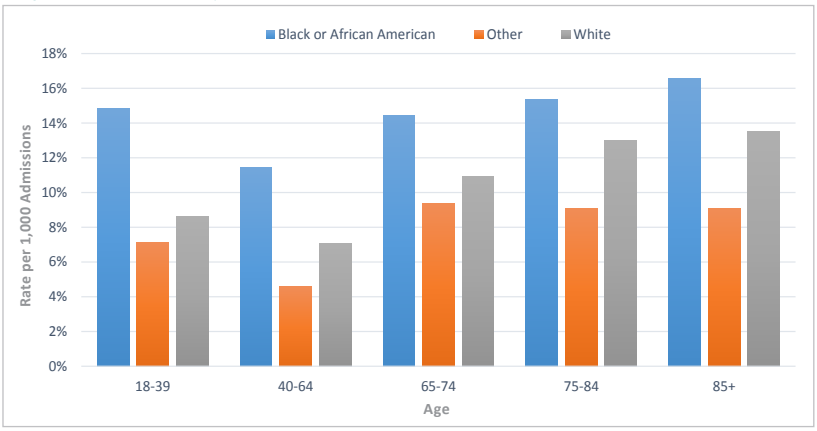
Source: Hospital Industry Data Institute, 2015.

Figure 11: Hospitalwide Readmissions by Race (2013-2015)



Source: Hospital Industry Data Institute, 2015.

Figure 12: AMI by Race (2013-2015)



Source: Hospital Industry Data Institute, 2015.

Missouri Health Equity Collaborative

Contributed by: Karen E. Edison, M.D., Director of the Center for Health Policy
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All Missourians should have the opportunity to make choices that allow them to live a long, healthy life, regardless of income, education, ethnicity, race, color, religion, national origin, sexual orientation, gender identity or expression, age, ability, and any other aspect of a person's identity. Health starts in our communities — where we live, learn, work, worship and play. As we collectively work to make good health and access to health care a reality for all Missourians, the Missouri Health Equity Collaborative supports efforts to ensure all Missourians have these opportunities.

MOHEC was established in 2004 as one of the Center for Health Policy's cornerstone projects at the University of Missouri. Supported by the Missouri Foundation for Health, MOHEC connects a vibrant network of individuals and organizations across Missouri working in the field of health disparities at various levels — academic, community and extension. MOHEC raises health disparity awareness in Missouri and creates collaborative partnerships that address community health, racial and ethnic health disparities, lesbian, gay bisexual and transgender health, mental health, and refugee and immigrant health equity. Our work has taken us throughout Missouri to Columbia, St. Louis, Kansas City, Springfield, Sikeston, Portageville, Cape Girardeau, Kennett, Senath, Milan, Cassville, Charleston, Joplin and Monett.

An essential part of understanding health disparities is an accurate portrayal of race, ethnicity, preferred language, sexual orientation and gender identity of people who seek and receive care. Accurate reflection of data is vital for health equity and for accurate reflection of health issues in underserved or vulnerable populations. Additionally, research has shown that making an appointment or going through check-in/intake can be a negative experience for traditionally underserved populations.

MOHEC is partnering with MHA, the Hospital Industry Data Institute, the Missouri Primary Care Association, PROMO, and Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders of PROMO Fund, to better understand how the registration and intake process, coupled with data collection practices, contributes to barriers to care, inaccurate data collection and ultimately poor health outcomes among vulnerable populations.[i]

Working in collaboration with MHA and HIDI, we completed an evaluation of data collection practices by surveying hospitals and speaking with clinical managers and patient access and front-desk staff about the challenges in collecting data. Research indicates that health care staff often feel discomfort when asking race, ethnicity, sexual orientation and gender identity questions and may not understand the terminology. They often express concern regarding patient accuracy in reporting, question the value of collecting a large amount of data from the patient and do not understand how the data is used. Additional challenges include inadequate or limited data collection fields in the electronic health record, limited time for data collection and the feeling that intake/registration staff are paid less with limited training and a high level of responsibility. This creates an environment where, according to the research, staff is more likely to use observation or guessing as collection methods instead of allowing the patient to self-identify.

Additionally, there are challenges on the patient side, such as privacy concerns, distrust in the health system's motivation for collecting data, fear of differential treatment, time concerns, lack of categories that accurately describe their identity and perceived offensive questions associated with data collection.[ii] Providers and staff are aware of these patient concerns and would like tools and resources to help patients understand how and why data are collected.

MOHEC is working with health care organizations in Missouri to reduce barriers to collecting race, ethnicity, language preference, sexual orientation and gender identity data by facilitating discussions and training staff on data collection, its legality and uses, and how to work with patients on data collection. We are working with clinic managers and front-line staff to create an understanding of the importance of collecting data and will provide guidelines and strategies for how to implement the procedures and explain the purpose to patients. Equipping staff with these skills can help organizations successfully carry out their data collection and health equity efforts.

To achieve inclusive health care environments, health care providers and staff need to explore how identity and culture shape experiences in the health care setting. It also is important to learn how identity and culture underlie situations that often go unnoticed in health care workplaces. This proactive, inclusive approach empowers health care providers and staff to address health disparities and will increasingly be considered a crucial skill in the health care sector.

[i] National Center for Cultural Competence, Georgetown University Center for Child and Human Development, Centers for Excellence in Developmental Disabilities. *Cultural competence: It all starts at front desk.* Retrieved from http://nccc.georgetown.edu/documents/FrontDeskArticle.pdf

[ii] Hasnain-Wynia. R. & Baker. D. (2006). Obtaining Data on Patient Race, Ethnicity, and Primary Language in Health Care Organizations: Current Challenges and Proposed Solutions. *Health Services Research, 41, Issue 4p1,* 1501-1518.

Project ECHO

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Project ECHO (Extension for Community Healthcare Outcomes) connects specialists from urban academic medical centers with rural providers with the aim of improving health care outcomes for people with chronic diseases.[vi] Project ECHO was created by Dr. Sanjeev Arora at the University of New Mexico in 2003 to help care for Hepatitis C patients. The project was designed to educate and mentor primary care providers from rural areas through telehealth technologies in a specific disease state so they can care for patients in their communities.[vi] Since then, Project ECHO has been replicated in more than 40 disease states in the U.S. and abroad.

Missouri is a predominately rural state — more than 90 percent is rural, with 30 percent of the total population living in rural areas.[vii] In addition, only about 10 percent of Missouri providers practice in those areas.[iii] This shortage of providers results in the lack of timely and adequate care for rural Missourians. To help address this issue, the Missouri Telehealth Network at the University of Missouri partnered with the University of New Mexico to replicate Project ECHO. Show-Me ECHO, led by MTN, links six specialty teams in weekly or bi-weekly telehealth session with numerous primary care providers across the state to educate, facilitate, and mentor them in a case-based and non-judgmental learning environment.

The goal of Project ECHO is not only to improve the care of one patient, but also to enhance providers' knowledge and to use a "force multiplier effect." This knowledge will be used to tackle the burden of chronic diseases in the setting of limited health care providers and funding. Patients from rural areas now will have access to high-quality care and timely treatment through providers participating in Show-Me ECHO.

Figure 13: Show-Me ECHO Timeline

Source: Missouri Telehealth.

Suggested Citation

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[i] American Hospital Association, Association of American Medical Colleges, American College of Healthcare Executives, Catholic Health Association of the United States, and National Association of Public Hospitals and Health Systems. (2012). *Eliminating health care disparities: Implementing the national call to action using lessons learned.* Chicago.

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[iv] Benz, J. (2011, October 30). Awareness of racial and ethnic disparities has improved only modestly over a decade. *Health Affairs.*

[v] Centers for Disease Control and Prevention. (2013, November 22). CDC health disparities and inequalities report-United States, 2013. *Morbidity and Mortality Weekly Report,* 189.

[vi] Arora, S., Thornton, K., Jenkusky, S., Parish, B., & Scaletti, J. (2007). *Project ECHO: Linking university specialists with rural and prison-based clinicians to improve care for people with chronic Hepatitis C in New Mexico. 122*(2).

[vii] *Missouri census data: Ten things to know about urban vs. rural.* (2014, June 27). Retrieved from http://mcdc.missouri.edu/TenThings/urbanrural.shtml

Other Resources

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