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HOW CLINICIAN BIAS MAY CONTRIBUTE TO HEALTH INEQUITIES!

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NWPSC Webinar

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"Working to Achieve Health Equity"

The Concept of Health Equity

Health Equity is the fair distribution of health determinants, outcomes, and resources within and between segment of the population, regardless of social standing.

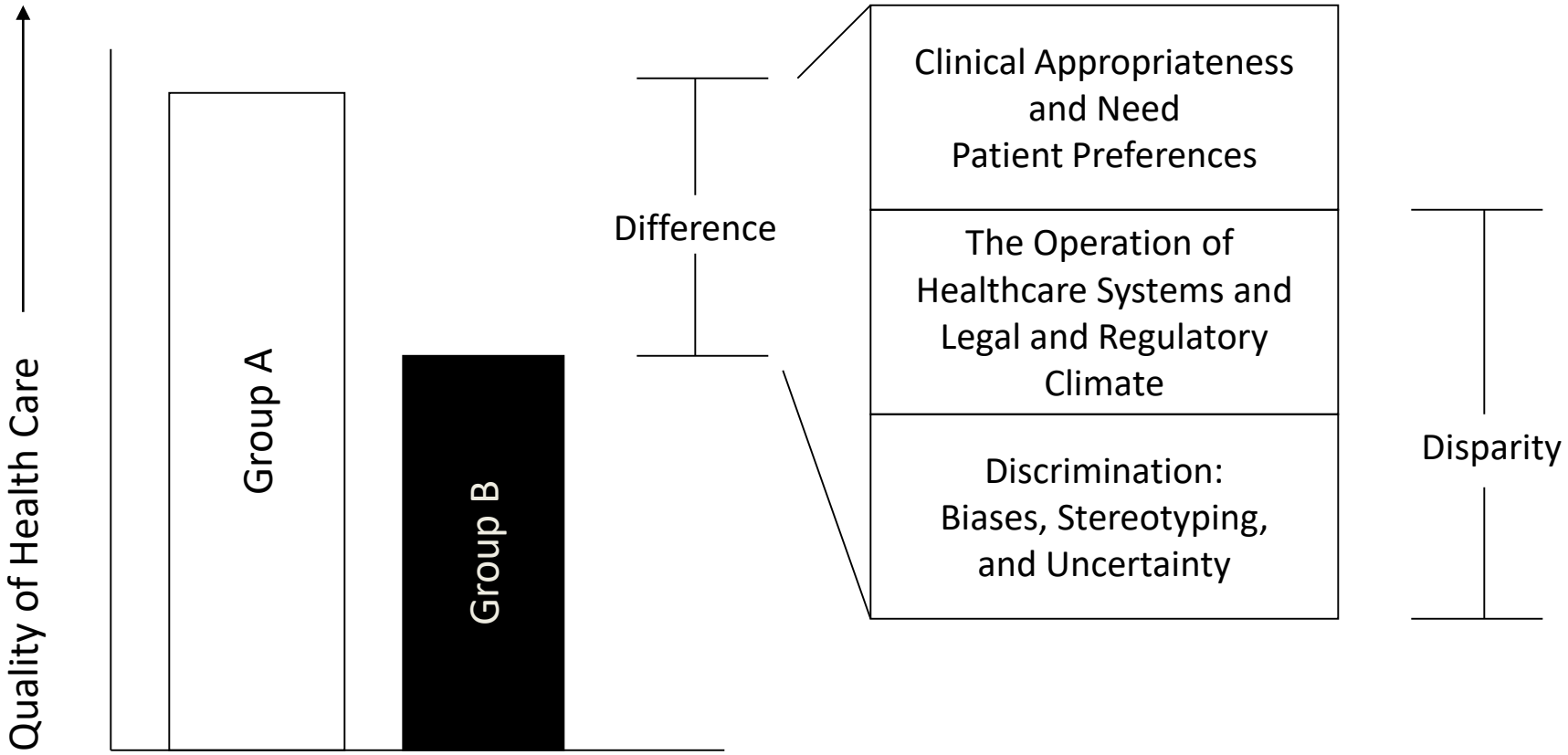
Working definition from the CDC Health Equity Work Group, October 2007

Distinctions Among the Concepts

Concept	Research question	Application to policy or program planning
Disparity	Is there a difference in health status rates between population groups?	Is the difference too large?
Inequity	Is the disparity in rates due to differences in social, economic, environmental or healthcare resources?	Is the distribution of resources *fair*?
Inequality*	How do rates vary with the amount of the resource, and how is the population distributed among resource groups?	Can the distribution of the population among resource groups and/or the rates within resource groups be influenced?
Burden	How many people are affected in specific groups and in the total population?	How many people would benefit from interventions?

*Questions and applications refer to ordered groups

What is a Health Care Disparity?



SOURCE: Figure 1. Differences, Disparities, and Discrimination: Populations with Equal Access to Healthcare. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, Summary*. Brian Smedley, Adrianne Stith, and Alan Nelson, Eds. Washington, DC. Institute of Medicine, 2002.

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Types of Health Disparities

- Racial & Ethnic
- Sex
- Socioeconomic Status
- Disability
- Geographic
- Sexual Orientation & Gender Identity

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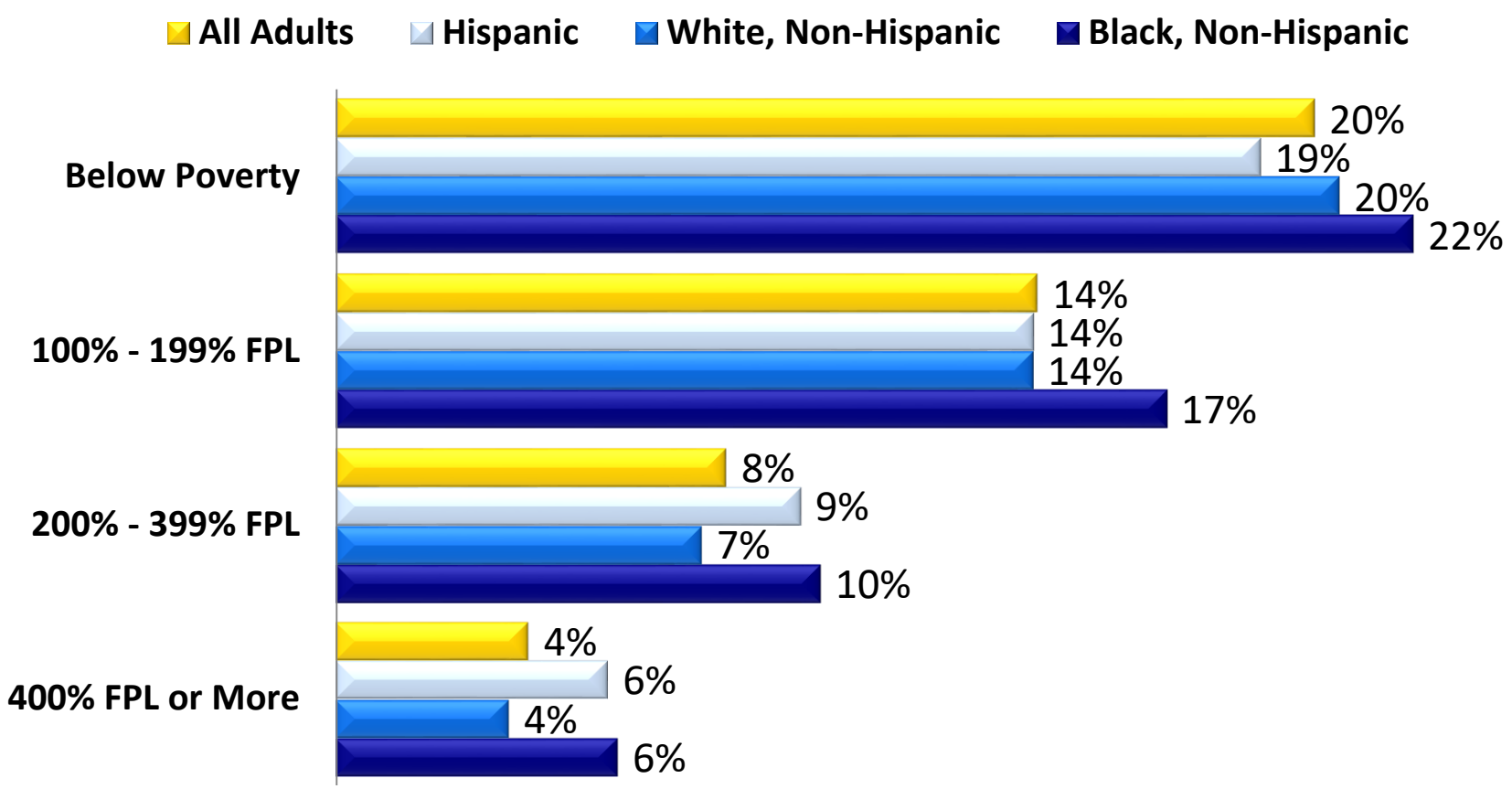
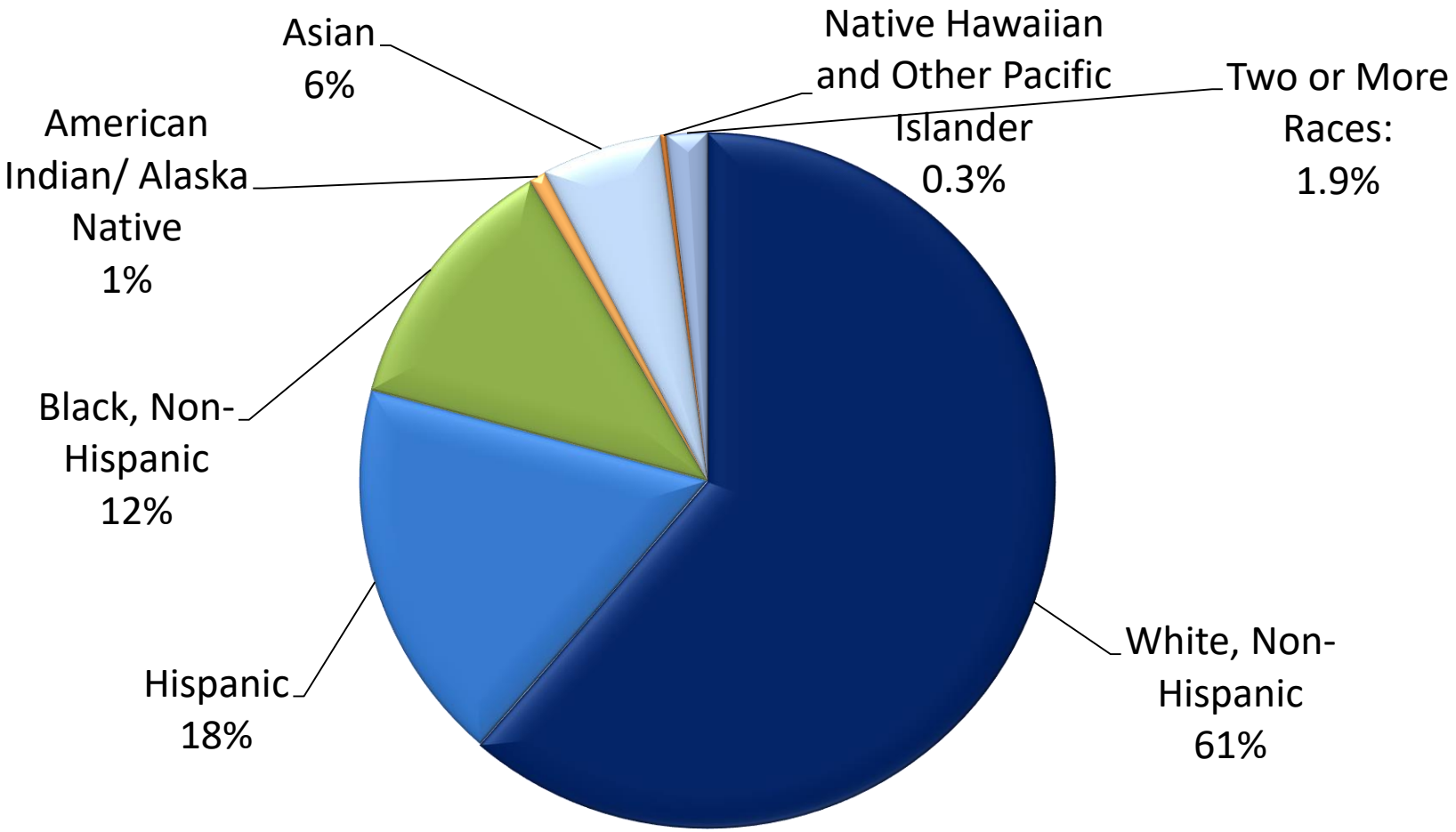
Fair or Poor Health Among Adults by Income and Race & Ethnicity, 2014



SOURCE: Table 45. Respondent-assessed health status, by selected characteristics: United States, selected years 1991–2014. *Health, United States 2015.* https://www.cdc.gov/nchs/data/hus/hus15.pdf

Distribution of U.S. Population by Race/Ethnicity, 2016



Total U.S. Population = 321.4 million

SOURCE: 2016 U.S. Census

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Factors that Impact Our Health

- Social Gradient
- Early Life
- Social Exclusion
- Work
- Unemployment
- Social Support
- Addiction
- Food
- Stress
- Transportation
- Environment/Community
- Health Insurance
- English Proficiency
- Health Literacy

SOURCE: Richard Wilkinson and Michael Marmot, eds. *Social Determinants of Health: The Solid Facts*, 2nd Edition. Denmark; World Health Organization, 2003. Available at http://www.euro.who.int/eprise/main/who/informationsources/publications/catalogue/20020808_2.

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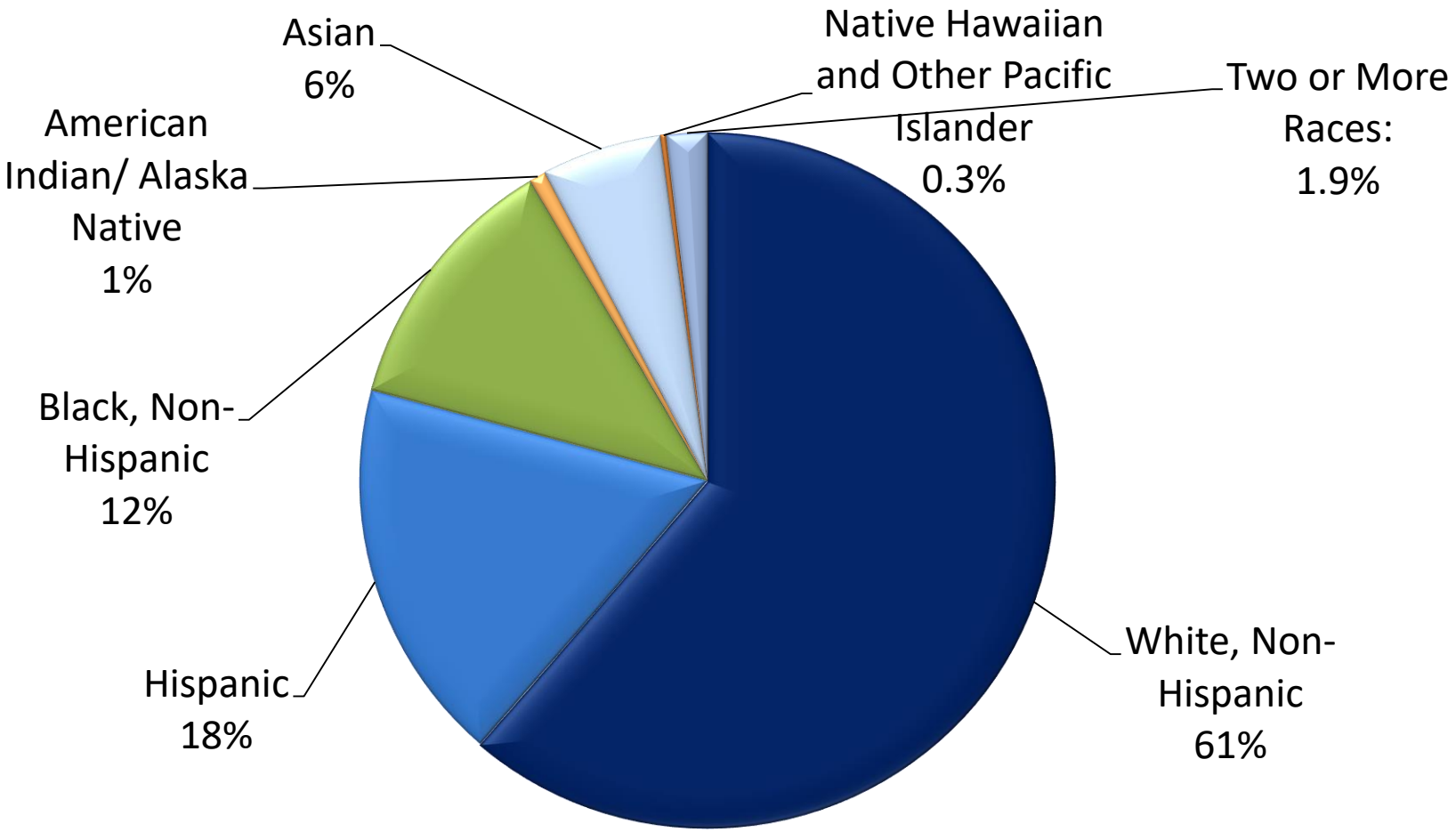

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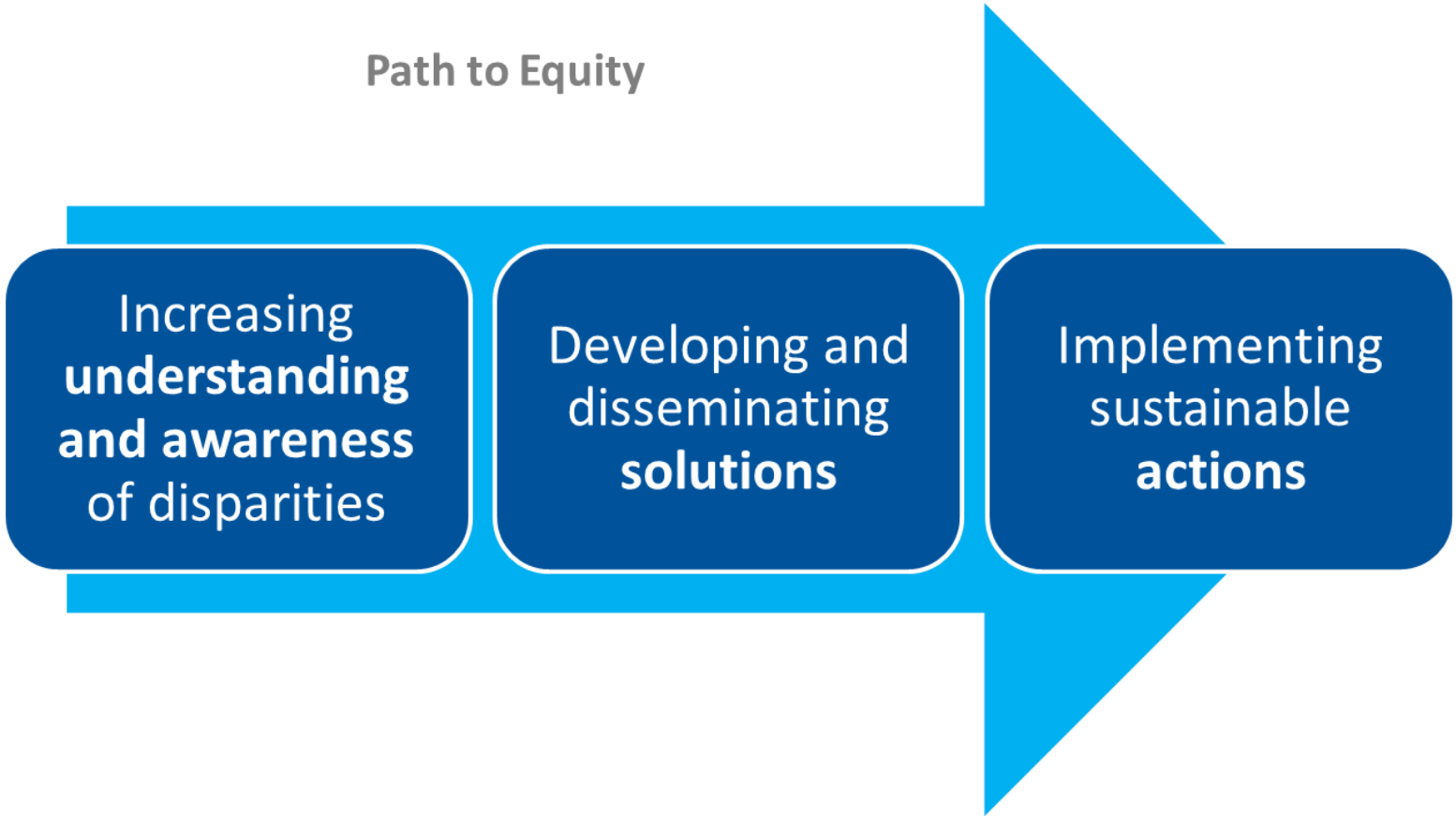
Path to Equity

Understanding, Solutions, Actions (U.S.A.)

Our path to equity in Medicare quality consists of three interconnected domains.



We All Have a Culture!

Culture is defined as the integrated pattern of thoughts, communications, actions, customs, beliefs, values, and institutions associated, wholly or partially, with racial, ethnic, or linguistic groups, as well as with religious, spiritual, biological, geographical, or sociological characteristics.

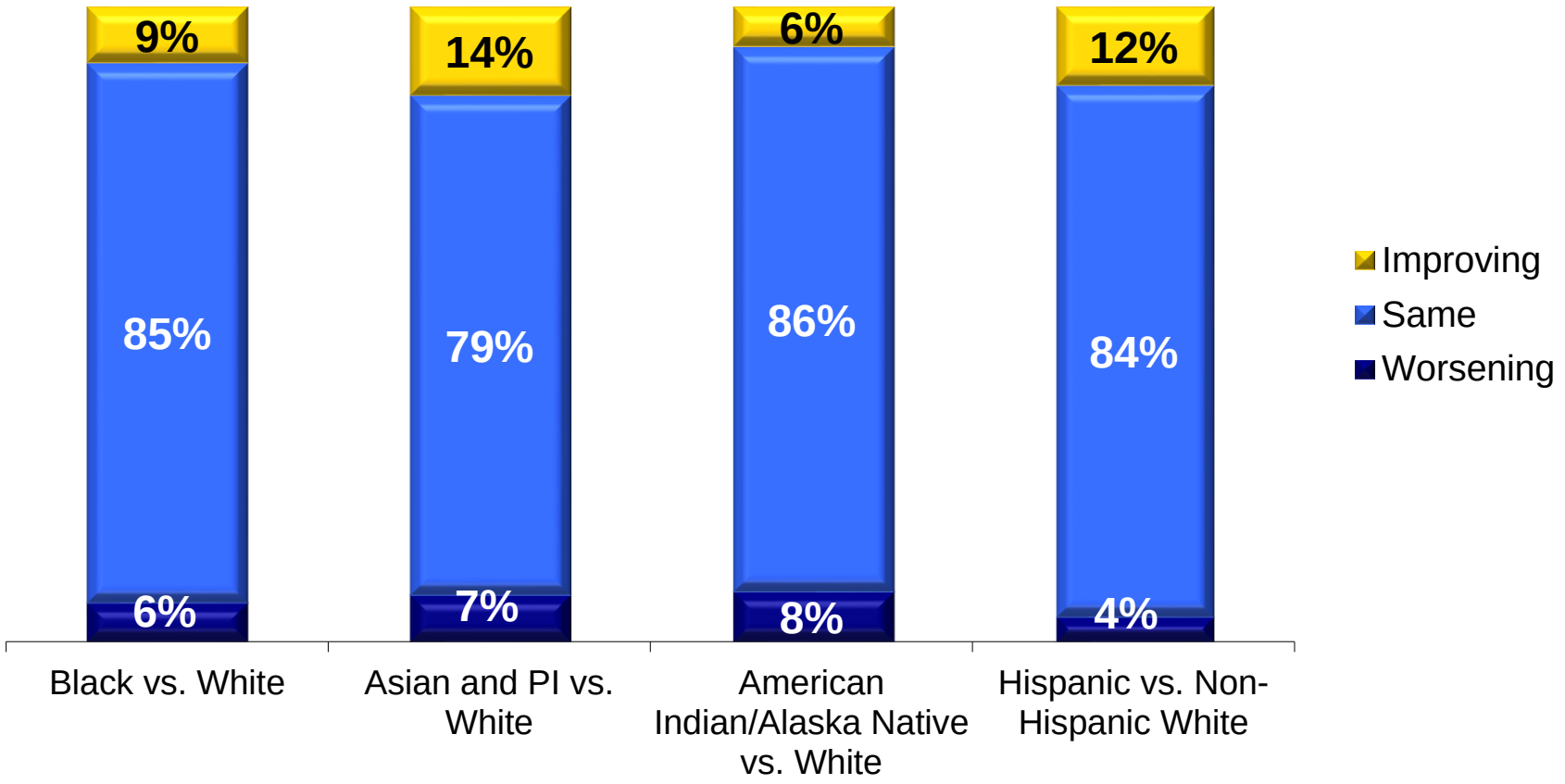
Culture is dynamic in nature, and individuals may identify with multiple cultures over the course of their lifetimes.

- Gilbert, Goode, & Dunne, 2007; HHS OMH, 2005)

Addressing Health Disparities at All Levels

Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion. (2011). Social Ecological Model. Retrieved March 17, 2015. From http://www.cdc.gov/cancer/crccp/sem.htm.

Changes in Quality of Care Disparities Over Time: Summary by Race and Ethnicity, 2014



NOTES: "Improving" means disparity is becoming smaller over time; "worsening" means disparity becoming larger over time. Data on all measures are not available for all groups. Totals may not add to 100% due to rounding. Time period differs by measure and includes oldest and newest years of available data.

SOURCE: AHRQ, National Healthcare Disparities Report, 2014.

CMS Equity Plan Priorities

Priority 1: Expand the Collection, Reporting, and Analysis of **Standardized Data**

Priority 4: Increase the Ability of the **Health Care Workforce** to Meet the Needs of Vulnerable Populations

Priority 2: Evaluate **Disparities Impacts** and Integrate Equity Solutions Across CMS Programs

Priority 5: Improve **Communication & Language Access** for Individuals with LEP & Persons with Disabilities

Priority 3: Develop and Disseminate **Promising Approaches** to Reduce Health Disparities

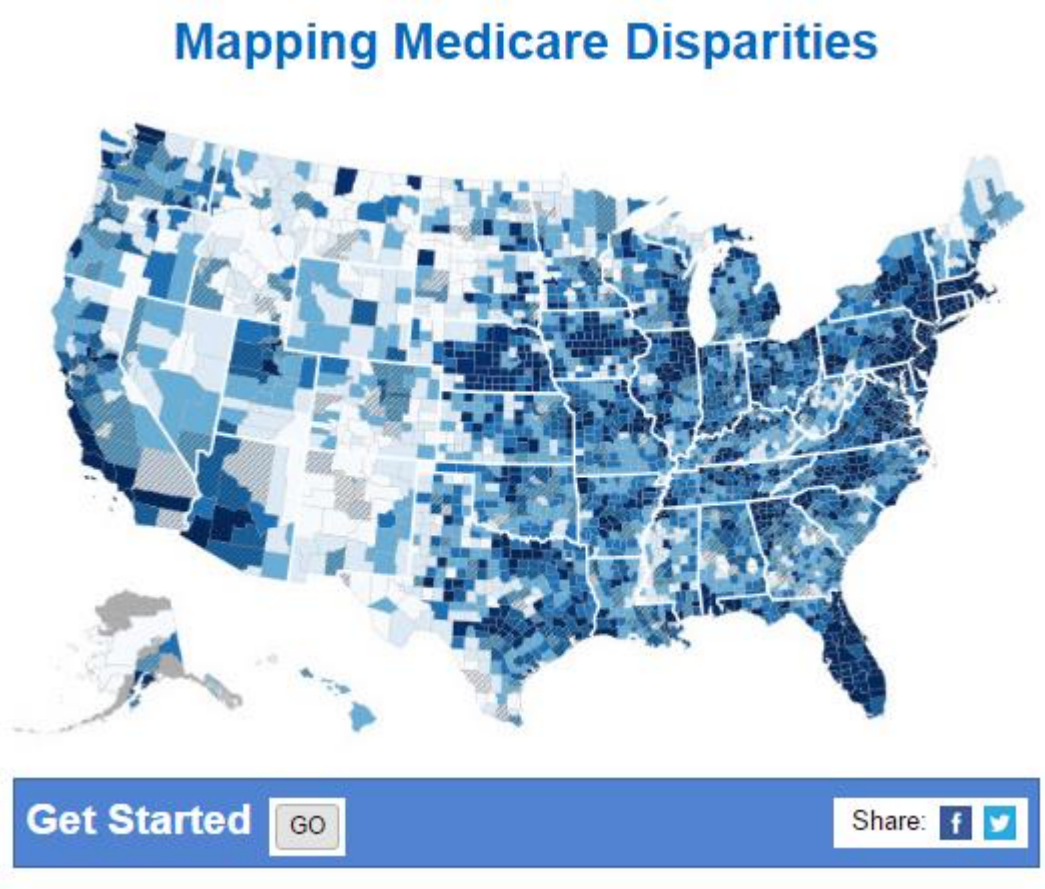
Priority 6: Increase **Physical Accessibility** of Health Care Facilities

Current CMS OMH Efforts: Data Collection Standards

- Required by Section 4302 of the Affordable Care Act for the following:
  - -Race
  - -Ethnicity
  - -Primary Language
  - - Sex
  - - Disability
- Secretary has the authority to add other categories (e.g. socioeconomic status and sexual orientation)

Mapping Medicare Disparities Tool

Built-in benchmarking features to investigate disparities between subgroups



Visualize:

- Disease Prevalence
- Cost
- Readmissions
- Mortality
- PQIs
- ED Utilization

Stratify by:

- Age
- Race
- Ethnicity
- Dual Eligibility

HERE

National, State, or County Level Comparisons

Priority 2: Evaluate disparities impacts and integrate equity solutions across CMS programs

CMS OMH will work with colleagues to increase understanding of the **disparities impacts** of CMS programs and **to build equity solutions** into ongoing and future programs.

Accountable Health Communities Model

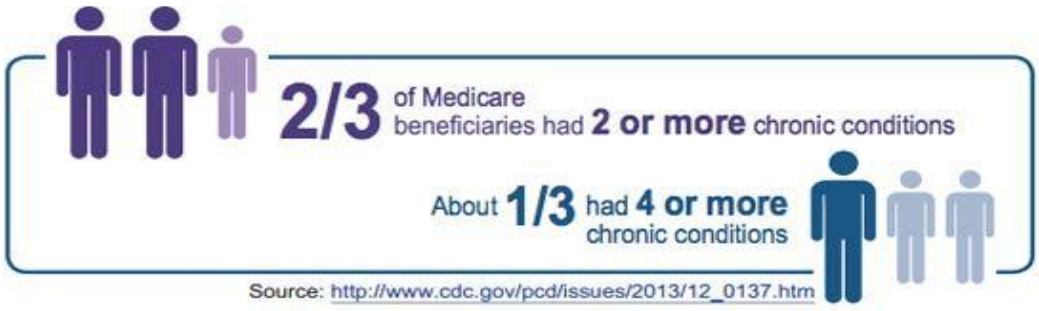
- The Accountable Health Communities Model is a 5-year model that tests whether systematically identifying and addressing the health-related social needs of community-dwelling Medicare and Medicaid beneficiaries impacts health care quality, utilization and costs.

Chronic Care Overview

- Half of all adult Americans have a chronic condition – 117 million people
- One in four Americans have 2+ chronic conditions
- 7 of the top 10 causes of death in 2010 were from chronic diseases
- People with chronic conditions account for 84% of national healthcare spending
- Racial and ethnic minorities receive poorer care than whites on 40% of quality measures, including chronic care coordination and patient-centered car є

CMS + CHRONIC CARE

- Medicare benefit payments totaled $597 billion in 2014
- Two-thirds of Medicare beneficiaries have 2+ chronic conditions
- 99% of Medicare spending is on patients with chronic conditions
- Annual per capita Medicare spending increases with beneficiaries' number of chronic conditions



Sources: CMS, CDC, Kaiser Family Foundation, AHRQ

Priority 3: Develop and disseminate promising approaches to reduce health disparities

CMS OMH will **develop, test, and diffuse promising approaches** to reducing health disparities. We will start by focusing on readmissions and improving nursing home care for vulnerable populations.

Priority 4: Increase the ability of the health care workforce to meet the needs of vulnerable populations

CMS OMH will promote a **culturally competent workforce and multidisciplinary teams** by building the science and business case for community health workers and by building capacity for providers to meet national CLAS standards.

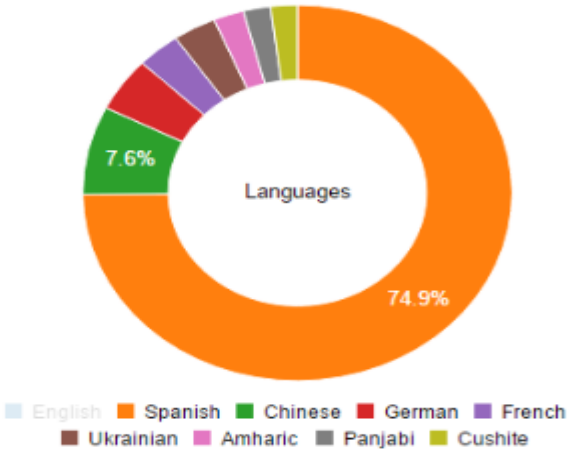
Priority 5: Improve Communication and Language Access for Individuals with Limited English Proficiency and Persons with Disabilities

CMS OMH will help **improve communication for vulnerable populations** by assessing language access needs, educating providers, and sharing best practices.

Language Diversity

Languages Spoken in Washington

Language	Population	Percentage
Population 5 years and over	6,378,045	100
English	5,536,216	86.8
Spanish	521,720	8.18
Chinese	52,980	0.83
German	32,475	0.51
French	22,710	0.36
Ukrainian	22,710	0.36
Amharic	15,960	0.25
Panjabi	14,265	0.22
Cushite	13,925	0.22



This chart shows the top 10 non-English languages that are spoken at home in Washington. The data comes from the most recent release of the American Community Survey (ACS).

Other Languages Spoken at Home in the United States, 2009-2013

- More than 60 million people speak a language other than English at home
- More than 25 million (41%) speak English less than "very well" (LEP)
- Top 10 Languages in US other than English:

1.	Spanish	37.5 million	6.	Korean	1.1 million
2.	Chinese	2.9 million	7.	Arabic	1.1 million
3.	Tagalog	1.6 million	8.	German	0.92 million
4.	Vietnamese	1.4 million	9.	Russian	0.88 million
5.	French	1.3 million	10.	French Creole	0.74 million

SOURCE: *Detailed Languages Spoken at Home and Ability to Speak English for the Population 5 Years and Over for United States: 2009-2013.* U.S. Census Bureau. Last Revised: October 28, 2015.

Priority 6: Increase physical accessibility of health care facilities

CMS OMH will **measure the physical accessibility of health care facilities** for people with disabilities and identify effective strategies to improve access .

Health Disparities among People with Disabilities

Health Indicator	People With Disabilities (%)	People Without Disabilities (%)	Data Source
Health care access			
In past year, needed to see doctor but did not because of cost[a]	27.0	12.1	BRFSS 2010
Women current with mammogram[a]	70.7	76.6	BRFSS 2010
Women current with Pap test[a]	78.3	82.3	BRFSS 2010
Health behaviors			
Adults who are obese[a,b]	44.6	34.2	NHANES 2009–2010
Adults who smoke (100 cigarettes in lifetime and currently smoke)[a]	28.8	18.0	NHIS 2010
Annual no. of new cases of diagnosed diabetes (per 1000 persons)[a]	19.1	6.8	NHIS 2008–2010
Adults with cardiovascular disease			
18–44 y	12.4	3.4	NHIS 2009–2011
45–64 y	27.7	9.7	NHIS 2009–2011
Adults reporting sufficient social and emotional support[a]	70.0	83.1	BRFSS 2010
Social determinants of health			
Internet access	54	85	NOD 2010
Household income < $15 000	34	15	NOD 2010
Inadequate transportation	34	16	NOD 2010

[a]Age-adjusted.
[b]Obesity defined as a body mass index of ≥ 30 kg/m^2.
BRFSS = Behavior Risk Factor Surveillance System; CPS = Current Population Survey; NCVS = National Crime Victimization Survey; NHANES = National Health and Nutrition Examination Survey; NHIS = National Health Interview Survey; NOD = National Organization on Disabilities Survey of Americans with Disabilities; All differences reported are statistically significant.
Source: Krahn GL, Walker DK, Correa-De-Araujo R. Persons With Disabilities as an Unrecognized Health Disparity Population. *American Journal of Public Health*. 2015;105(Suppl 2):S198-S206. doi:10.2105/AJPH.2014.302182.

Challenges and Opportunities:

Where You Live Matters!

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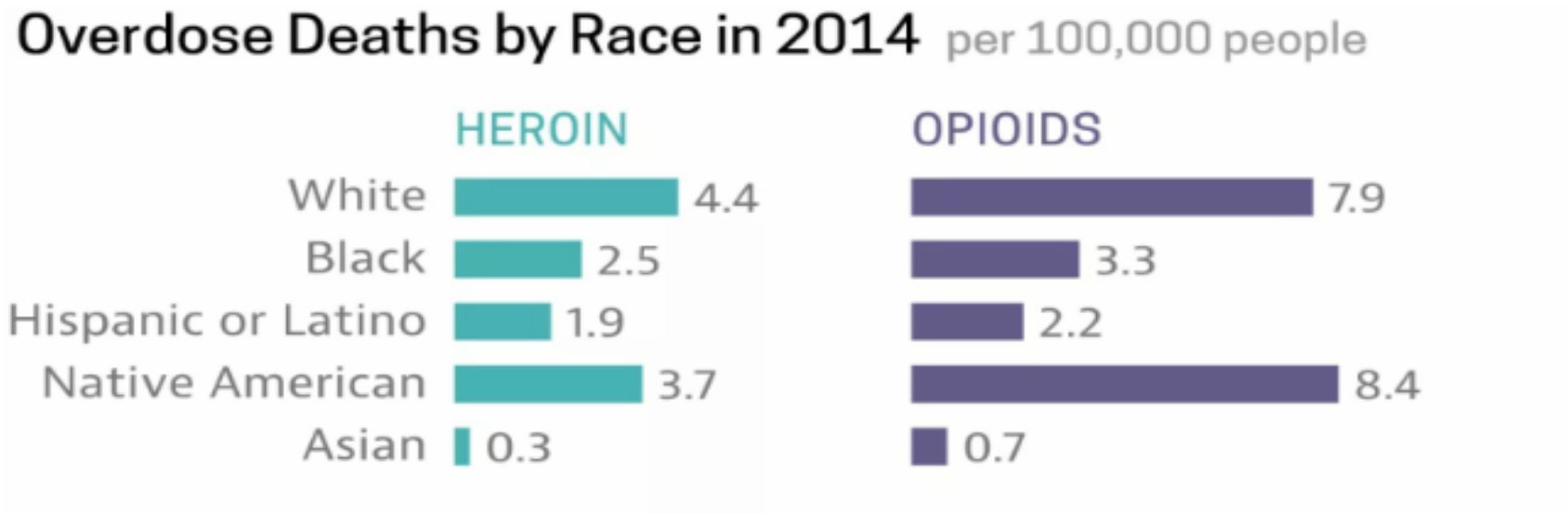
Racial/Ethnic Differences in Opioid-related Fatalities

Although prescription drug abuse and heroin use impacts every racial demographic, some population groups have been affected more than others.



Nolan, D., & Amico, C. (2016, February 23). *How Bad is the Opioid Epidemic?* Retrieved April 12, 2017, from http://www.pbs.org/wgbh/frontline/article/how-bad-is-the-opioid-epidemic/.

Quality Improvement & Interventions

Uncover and solve the root cause of significant health disparities by embedding health equity into the organizations quality improvement activities

QUALITY IMPROVEMENT

INTERVENTIONS

Join us on the path to health equity!

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Conclusion

"A journey of a thousand miles begins with a single step." (Lao-tzu, 604 BC - 531 BC)

Together we can ensure that all Americans have access to quality affordable health coverage, and that health disparities are eliminated.

Health Equity Technical Assistance

For Health Equity Technical Assistance on these resources, contact us at

HealthEquityTA@cms.hhs.gov

CMS OMH Homepage:

go.cms.gov/omh

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