High Value Health Care for Diverse Populations

Session Objectives

- Present evidence on disparities in health care
- Identify links between value, quality, and equity
- Describe the approaches taken by healthcare organizations to deliver quality care to diverse populations
**Agenda**

| Welcome and brief summary on the field of disparities and the Disparities Leadership Program | Disparities Solutions Center  
Dr. Lenny López, MD, MDiv, MPH  
Aswita Tan-McGrory, MBA, MSPH |
|---|---|
| Hunger-free Hospital Model: Improving access to food with food insecurity screening and writing prescriptions for a fresh food program | St. Christopher’s Hospital For Children  
Hans Kersten, MD |
| Refining HCMC Collection Efforts of REaL Data | Hennepin County Medical Center  
Karoline Pierson, MA |
| Audience Q&A and wrap up | |

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**Improving Quality and Achieving Equity in a Time of Healthcare Transformation**

*The Pursuit of High-Value Health Care*

Lenny López, MD, MDiv, MPH  
Senior Faculty, Disparities Solutions Center  
Assistant in Health Policy, Mongan Institute for Health Policy  
Assistant Professor, Harvard Medical School  
Massachusetts General Hospital
Outline

• Key Drivers

• High-Value, Transformation and Equity

• Lessons from the Field

Disparities in Health Care 2002

Racial/Ethnic disparities found across a wide range of health care settings, disease areas, and clinical services, even when various confounders (SES, insurance) controlled for.

Many sources contribute to disparities—no one suspect, no one solution

• Provider-Patient Communication
• Stereotyping
• Mistrust
Cost of Disparities

- Between 2003 and 2006, the combined direct and indirect cost of health disparities in the United States was $1.24 trillion (in 2008 inflation-adjusted dollars).
Key Drivers

Full-Circle of Disparities

- Health Care
- Labor Market
- Justice System
- Housing
- Education
- Consumer Credit
Linking Disparities to Quality and Safety

- Safe
  - Minorities have more medical errors with greater clinical consequences
- Effective
  - Minorities received less evidence-based care (diabetes)
- Patient-centered
  - Minorities less likely to provide truly informed consent; some have lower satisfaction
- Timely
  - Minorities more likely to wait for same procedure (transplant)
- Efficient
  - Minorities experience more test ordering in ED due to poor communication
- Equitable
  - No variation in outcomes
- Also
  - Minorities have more CHF readmissions, ACS admissions, and longer LOS

The Newly Insured Population
Approximately 50% Minority

What will the newly insured look like?
The newly insured compared to the currently insured are:

- **Race**
  - White: 75%
  - Black: 92%
- **Health status**
  - Excellent/Very good: 88%
  - Single: 92%
- **Marital status**
  - Less likely to be single: 52%
  - More likely to be single: 29%
- **Language**
  - Less likely to speak English: 88%
  - More likely to speak English: 69%
- **Educational attainment**
  - Less likely to have a college degree: 14%
  - More likely to have a college degree: 59%
- **Employment status**
  - Less likely to have full-time employment: 42%
  - More likely to have full-time employment: 37%

Created by PdF Health Research Institute. www.healthreformexposed.com
Accreditation, Quality Measures, and HC Reform

- Joint Commission: Disparities/Cultural competence Standards
- National Quality Forum: Disparities and Cultural Competence Quality Measures, developing disparities measures, incorporating into MAP
- AHA Call to Action: REaL Data, Governance, Cultural Competency Training
- Health Care Reform has multiple provisions addressing disparities

High-Value in a Time of Healthcare Transformation

Value-based purchasing and health care reform will alter the way health care is delivered and financed

- Increasing access: Assuring appropriate utilization
  - Decreasing ED use, linkage to primary care
- Paying for quality: ACO's and PCMH's
  - Importance of Wellness, Population Management, Preventing ACS
- Controlling cost: Transitions, safety and patient experience
  - Importance of hot spotting, preventing readmissions, avoiding medical errors, and improving patient satisfaction
Lessons from the Field

Quality and Disparities

- R/E Data Collection, Registries, Dashboards, QI, Carrots/Sticks

Provider

- CC Education
- Facilitate adherence to guidelines

System

Patient

- Screen for vulnerabilities
- Provide focused education, activation, navigation

Equity
1. Gather the Data

REaL Data Collection

- Collect REaL and Education data of all patients
  - Piloted different versions
    - Gets key info
    - Doesn’t confuse patients
    - Can be done in a timely fashion
  - Registrar Training
    - Preamble
    - FAQ’s
- PR Poster Campaign
- QA and Registrar Feedback
  - “Secret Santa”
  - Presentation on impact
- Net-Net: It can be done, is being done, no need to reinvent the wheel

2. Make the Data Useful

MGH Disparities Dashboard Executive Summary

- **Green Light:** Areas where care is equitable
  - National Hospital Quality Measures
  - HEDIS Outpatient Measures (Main Campus)
  - Pain Mgmt in the ED
- **Yellow Light:** National disparities, areas to be explored
  - Mental Health, Renal Transplantation
  - All cause and ACS Admissions (so far no disparities)
  - CHF Readmissions (so far no disparities)
  - Patient Experience (H-CAHPS shows subgroup variation)
- **Red Light:** Disparities found, action being taken
  - Diabetes at community health centers
    - Chelsea (Latino), Revere (Cambodian) Diabetes Project
  - Colonoscopy screening rates
    - Chelsea CRC Navigator Program (Latinos)
3. Develop Culturally Competent Interventions
Diabetes Disease Management Program

A quality improvement / disparities reduction program with 3 primary components:

- **Telephone outreach** to increase rate of HbA1c testing

- **Individual coaching** to address patients’ needs and concerns regarding diabetes self-management to improve HbA1c

- **Group education** meeting ADA requirements

*Also focus on link between mental health, chronic disease management, and prevention*
Diabetes Control Improving for All:  
Gap between Whites and Latinos Closing

<table>
<thead>
<tr>
<th>Year</th>
<th>% of Patients with Poorly Controlled Diabetes (HbA1c &gt; 8)</th>
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<tbody>
<tr>
<td>2007</td>
<td>37%</td>
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<tr>
<td>2008</td>
<td>24%</td>
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<tr>
<td>2009</td>
<td>24%</td>
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* Chelsea Diabetes Management Program began in first quarter of 2007; in 2008 received Diabetes Coalition of MA Programs of Excellence Award

4. Navigate to Access and Wellness

- Focus on Primary Care Linkage in ED & Community
- CRC Navigator Program
  - Initiated 2005
  - Use of registry to identify individuals, by race/ethnicity, who haven’t been screened for colon cancer
  - Navigator contacts patient (phone or live)
  - Determine key issues, assist in process
    - Education
    - Exploration of cultural perspectives
    - Logistical issues (transportation, chaperone)
  - GI Suite facilitates time/spaces issues

THE DISPARITIES SOLUTIONS CENTER
One Goal - High Quality Care for All
CRC Screening Over Time

Preparing for the Future

- Addressing variations in quality—such as racial/ethnic disparities in health care—will be essential going forward if we are achieve equity and high-value.

- This is not just about equity for equity’s sake—ethics and cost are key—as equity connects to all areas of quality:
  - Population Management
  - Transitions of Care and Readmissions
  - Appropriate Utilization and Avoidable Hospitalizations
  - Patient Safety
  - Patient Experience

- Hospitals ignore this at their own peril...action will separate winners from losers...
Our Vision: The Disparities Leadership Program

• To arm health care leaders with rich understanding of the causes of disparities and the vision to implement solutions and transform their organization to one delivering high-value care.

• To help leaders create strategic plans to advance their work in reducing disparities in a customized way, with practical benefits tailored to every organization.

• To align the goals of health equity with health care reform and other strategic imperatives designed to improve value.

Disparities Leadership Program Objectives

At the conclusion, participants will be able to:

• Articulate the ways in which equity is linked to healthcare transformation, health care reform, value-based purchasing, accreditation and quality measurement

• Identify strategies to secure buy-in by having health care leaders better understand these links and become invested in addressing them.

• List techniques and technology for race and ethnicity data collection and disparities/equity performance measurement.

• Identify interventions to reduce disparities in health care with a particular focus on preventing readmissions and avoidable hospitalizations, improving patient safety and experience, and deploying culturally competent population management initiatives.

• Identify ways to message the issue of equity both internally and externally.

• Describe a concrete step that their organization will take towards improving quality, addressing disparities and achieving equity.
Curriculum

• Two day kick off meeting in Boston in May
• Three web-based collaborative group calls
• Three team technical assistant calls
• Two web seminars on topics relevant to the DLP
• Two day meeting in CA in February

Disparities Leadership Program Alumni

• Disparities Leadership Program has trained:
  − 252 participants
  − 121 organizations
    • 61 hospitals
    • 28 health plans
    • 21 community health centers
    • 1 hospital trade organization
    • 1 federal government agency
    • 1 city government agency
    • 8 professional organizations
Post DLP Collaborations

- Transforming Healthcare: Intersection with Health Equity (Minneapolis)
- DLP Pediatric Working Group (Nashville, Kansas City)
- DLP Alumni meeting (Santa Monica)
- The Healthcare Quality and Equity Action Forum (Boston)
MN DLP Alumni Meetings

• Allina Hospitals and Clinics
• Children’s Hospitals and Clinics of MN
• Hennepin County Medical Center
• HealthEast Care System
• Mayo Clinic
• Regions Hospital
PHEC Data Domains

• Caregiver
• Race/Ethnicity
• Sexual Orientation and Gender Identity
• Disability
• Cultural Characteristics
• Language
The Healthcare Forum

September 29-30th, 2016
Boston Seaport Hotel

• Provides the background, key drivers and essential strategies to improve quality and achieve equity in a time of rapid healthcare system change.

• Sets the stage for an interdisciplinary dialogue between all key healthcare stakeholders, including payers and providers of services.

• Participants have included leaders from multiple disciplines and healthcare organizations—including those from health plans, healthcare systems, and children’s hospitals, to name a few—who work in the areas of:
  • quality and safety
  • disparities, diversity, and equity
  • health policy
  • healthcare design and delivery

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Reducing Disparities in Care: Exceptional Care Without Exception

Julia Joseph-Di Caprio M.D., M.P.H.
HCMC Chief of Pediatrics, Assistant Chief of Provider Services

Karoline Pierson
HCMC Director of Patient Access and Financial Care Services

Objectives

• Understand one organization’s readiness to rigorously collect and use REaL data
• Construct a one year project that provides the foundation to address health disparities
• Use project work to organize health disparities work
Who We Are

- Hennepin County Medical Center (HCMC)
  - Level 1 Trauma
  - Minnesota’s largest safety-net hospital and clinic system
  - 2/3’s of patients insured by public programs
  - Serves diverse communities
  - Interpreters for over 50 languages
- Minnesota-unique diversity

Background

- HCMC committed to addressing health disparities
- Internal HCMC support
  - Leadership support America’s Essential Hospitals National Call to
  - Mission Effectiveness Committee
  - HCMC joins Disparities Leadership program
Opportunities

• HCMC previously implemented REaL collection
  – Inconsistent definitions, training and scripting
  – Impact on data integrity
• No health disparities training for providers and staff
• No organized assessment of health disparities or program to address them

Project Scope

• Refine collection efforts of REaL data elements
• Partner with providers and leaders to develop tools aimed at eliminating disparities
• Examine outcomes in disease prevention/management and hospital readmission rates to look for disparities
Benefits of the Project

• Standardize REaL data collection methods
• Engage registration staff
• Ready the organization to assess and address health disparities
• Develop internal and external partnerships
• Expand toolbox of data collection tools

Challenges

• Fragmented approach to health disparities
• One of many organizational priorities
• Lack of resources – devoted FTEs
• Scope Creep
  – Once word got out everyone had an ask (e.g. homeless, disability, socio-economic status, gender, etc.)
• “No ONE (1) right answer”
• Budget
Solutions

• Addressing challenges
  – Project leaders have authority
  – Identify internal and external partners
  – Partner with similarly committed
  – Limit work
  – Offer solutions to others
  – Use Disparities Leadership Program expertise and tools

Lessons Learned

• Keep project scope realistic
• Link work to the organizational strategic goals
• Demonstrate value of health equity work
• Phase the work
• Use internal and external resources
• Remove data collection barriers
• Engage Patient Advisory Council
Next steps

• Develop work plan to address specific health disparities
• Further partnerships to identify new strategies to maintain and advance health disparities efforts
• Assess HCMC’s readiness to extend health equity work
ADDRESSING FOOD INSECURITY AND FOOD ACCESS WITH A HUNGER-FREE HOSPITAL MODEL

- St. Christopher’s Hospital for Children
  - Free-standing, non-sectarian for-profit academic children’s specialty hospital in North Philadelphia
  - Owned by Tenet Healthcare
  - ~230 pediatric specialists, combining expert general pediatric care with more than 30 different subspecialty areas
  - Center for the Urban Child (CUC), a 30,000 square-foot medical office building serving 25,000 patients located on the hospital’s main campus
  - Serves a large portion of the city’s underserved pediatric population in North Philadelphia, and consists of primarily black and Hispanic populations and Medicare insurance

ADDRESSING FOOD INSECURITY AND FOOD ACCESS WITH A HUNGER-FREE HOSPITAL MODEL

- Target population: Philadelphia
  - One of the poorest major cities in country
  - 26.6% families and 39.7% children live in poverty
  - 49.6% have food insecurity (FI)
HUNGER-FREE HOSPITAL CONCEPT

○ Project Bread

“hospitals ... unique opportunity in treating and preventing hunger”

- **Screen** – FI and other determinants of health
- **Provide** families resources
- **Educate** faculty, staff and community
- **Advocate** for patients/families
- **Care** - children/families with FI

http://www.projectbread.org/site/PageServer?page=about_main
ADDRESSING FOOD INSECURITY AND FOOD ACCESS WITH A HUNGER-FREE HOSPITAL MODEL

1. Identify best practice methods to screen for FI in CCAH, ED and Inpatient Units after analysis of recently compiled pilot data.

2. Optimize enrollment and follow-up of families enrolled in Farm to Families (F2F) and FreshRX programs utilizing pilot and F2F survey data.

ADDRESSING FOOD INSECURITY AND FOOD ACCESS WITH A HUNGER-FREE HOSPITAL MODEL

**Resources**
- Corporate buy-in
  - Local and national
- Collaborative working environment
- Medical Legal Partnership (MLP)
- Interested personnel

**Barriers**
- Disparate corporate efforts
  - Local versus national
- Limited time
  - 70% clinical FTE
- Limited personnel
  - Residents and students
- Expanding roles
  - Difficult to manage it all
- No expert or “buddy”

St. Christopher’s Hospital for Children  Drexel University College of Medicine
VALIDATED 2-ITEM FOOD INSECURITY SCREEN

1. “Within the past 12 months we worried whether our food would run out before we got money to buy more”
2. “Within the past 12 months the food we bought just didn't last and we didn't have money to get more.”

- 94% sensitive, 87% specific for FI
- Associated with risk of child poor/fair health
- Practical and easy to use in busy practice


FI SCREENING IN CCAH

- Screening
  - Began in CCAH
  - Incorporated into EHR
  - Began screening in ED and Inpatient Units (2013)
- 2-item FI questionnaire
  - PhilaKids MLP in CCAH since 2011
    - 5638 surveys completed

CCAH FI Screening with MLP
FI SCREENING IN THE ED

- First year screening
  - Total monthly screened = 4084-5282
  - Percent ED visits screened = 70-85% visits
  - Number +FI = 468
  - Range % + = 0.42-1.45

- Loss local FI champion
- QI project forming

FARM TO FAMILIES AND FRESHRX PROGRAMS

- Provide affordable, fresh, local food
- Bi-weekly or weekly distribution
- Cash or EBT card purchase
- $10 or $15 boxes of food
- Food demonstration with dietician
- Developed prescription program - FreshRX
  - Directly links physicians to healthy food
    - Increase credibility of provider
    - Discount on box with RX
FARM TO FAMILIES

- North Philadelphia
  - >40,000 boxes distributed

- St. Christopher’s Hospital
  - Begun September 2011
    - >1600 registered clients
    - >5878 boxes distributed
  - FreshRX program
    - >2842 written
    - >443 redeemed (drop from 25% to 16%)
  - >90% redeemed FRX make < $25,000/yr
  - Distribute ~25 boxes every week
  - Participants say F2F is: a “good price”, “convenient”, “affordable”, and “easy to use”

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FARM TO FAMILIES

Rx vs. Order Quantities

- Cumulative Rx Collected
- Cumulative Rx Redeemed
- Cumulative Orders
% FRX followed up - ↑ from 23 to 74%
# boxes/week - ↑ 26 to 46 boxes
% FRX redeemed - ↑ 13-31%

**ADDRESSING FOOD INSECURITY AND FOOD ACCESS WITH A HUNGER-FREE HOSPITAL MODEL**

**Challenges:**

1. Balance clinical, advocacy, family time
2. Small coalition to share workload
   a. F2F understaffed
   b. Difficult to manage all initiatives
3. Difficult to sustain momentum
4. Funding to expand efforts

**Successes:**

1. Hunger Summit with government relations executives
2. F2F and FI write-ups
3. Building FI and F2F teams
4. Meeting with F2F team scheduled
5. Regional presentations
6. National FI Screening workshop
7. Pat Temple-West Award from Coalition Against Hunger
ADDRESSING FOOD INSECURITY AND FOOD ACCESS WITH A HUNGER-FREE HOSPITAL MODEL

Take Away Points:
1. Hospitals uniquely situated to address FI and other social determinants of health
2. Corporate buy-in can lead to variety initiatives to address FI
3. Partnering with colleagues and community partners are critical for success of programs
4. Important to celebrate successes and communicate progress
5. Must build coalition of people to improve and sustain programs

For More Information the Disparities Leadership Program

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