



Disparities in Care 2014 report

July 2014

Dear Alliance Member,

The Institute of Healthcare Improvement's Triple Aim — improving the experience of care, health of a population, and per capita cost — has rapidly become the framework for improving health care in Washington state. Some Washington health care organizations have risen to the challenge and are developing innovative approaches to address the move toward a population-health focus.

Health disparities refer to the differences in health and health care received among groups of people. These differences reveal how frequently a disease affects a group, whether a group receives appropriate care for their disease, or how often the disease causes disability or death. Some groups are more likely to be affected by disparities, including ethnic and racial minorities, women, children or the elderly, or persons with disabilities. Disparities are typically related to underuse of effective, evidence-based care.

Through the population health lens, disparities in care can be seen as the failure—or success—of effective population management. Organizations that work to improve disparities also focus on their biggest breakdowns in the care process and thereby work to improve the care for all of their patients and community members. Improving disparities in care, therefore, is a key to addressing successful population management.

Last year the Alliance released the first Disparities in Care report. Because the report provided a data-driven analysis of the issue, it received considerable attention from health care and policy organizations across the state. In this year's report we are pleased to provide, for the first time, statewide results and qualitative data from survey and stakeholder interviews, providing a more comprehensive look at how Washington is providing care as well as the potential causes of these gaps of care.

To produce this report, the Alliance has stratified the 2013 Community Checkup Medicaid data by race, ethnicity, and language, the only population for whom this analysis can be done with claims data. Our report focuses on *process* and the delivery of care for Medicaid enrollees. This is a different perspective than many disparities reports, which often look at health *outcomes*. Many national and state reports have shown how many populations are disproportionately impacted by disease and health status. However, the Alliance report provides insight into how many of these same populations are not receiving the care they need, thus showing a relationship between higher disease rates and underuse of effective care.

In addition to this report, the Alliance has prepared clinic-level reports, shared privately with provider groups, and county-level Disparities in Care reports, providing crucial details and, hopefully, more actionable data for providers across our state. Please contact the Alliance if you are interested in learning more about the disparities reports. You can also view the Community Checkup clinic and county level results for Medicaid and commercial plans at: www.wacommunitycheckup.org.

The findings in this report demonstrate that racial and ethnic disparities are indeed a problem in Washington State. The Alliance hopes that these findings will provide a call to action that will lead to effective quality improvement efforts to improve the health of all the people in our state.

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Background: Disparities in health care

Racial and ethnic minority patients experience lower quality of care and health outcomes than their White counterparts. The U.S. Department of Health and Human Services Healthy People 2020 Report^{1,2} and the Agency for Healthcare Research and Quality (AHRQ) National Healthcare Disparities Report³ show widespread disparities in cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, immunizations, and infant mortality.^{1,2} Moreover, racial and ethnic minority patients receive worse care than White patients even after accounting for education and socioeconomic status.³ For example, Hispanic patients receive worse care than non-Hispanic White patients for approximately 40 percent of Medicaid-identified quality measures and American Indian/ Alaska Natives (AI/AN) receive worse care for one-third of quality measures.

Disparities in care also place a significant financial burden upon larger health care systems. The Joint Center for Political and Economic Studies shows that the combined costs of health inequalities and their resulting premature death in the United States were \$1.24 trillion between 2003 and 2006. Moreover, within these three years, it is estimated that eliminating health disparities for minorities would have reduced direct medical care expenditures by \$229.4 billion.⁵ Poor quality care often results in more expensive or unnecessary tertiary care, especially for diseases such as diabetes, in which tertiary treatment is often significantly more expensive than preventing or delaying disease onset through adequate, earlier preventive care.⁶

The financial burden of inadequate care is not limited to healthcare-related costs. Human capital costs of diseases, such as absenteeism from the workplace and disability, are significantly higher than direct medical costs. Lost productivity related to employee and family poor health cost U.S. employers an estimated \$225.8 billion annually.⁷ While these financial burdens are a consequence of poor care to all patients, minority patients are most at risk for receiving poor quality care. Therefore placing efforts on reducing disparities in care for minority patients provides an opportunity to address the overall financial burden of healthcare costs.

Shifting racial and ethnic demographics makes addressing these disparities in care all the more urgent. The 2010 National Census showed that approximately one third of the population of the U.S. belong to a racial or ethnic minority population, and projections estimate that by 2043, minority populations will comprise a majority of the U.S. population.⁸ Demographic shifts within Washington state follow national trends. For instance, the racial ethnic minority population within the state increased from 20.6 percent in 2000 to 27.3 percent in 2010. As minority populations continue to grow, it will be imperative to address disparities in care.

Recent efforts implemented by the Affordable Care Act (ACA) will ensure that more racial and ethnic minority patients will be covered by Medicaid. As part of the push to increase health insurance coverage, the ACA is expanding Medicaid coverage to adults with incomes at or below 138 percent of the federal poverty level (FPL) which will significantly impact racial ethnic minority patients. The Medicaid expansion offers a unique opportunity to increase coverage among racial and ethnic minority patients; 53 percent of uninsured

The quality of health care services is commonly evaluated by the Institute of Medicine's aims that ask if the outcomes of care are: safe, effective, patient-centered, timely, efficient, and equitable.⁴ This report focuses on quality areas around: access to care, health screenings, appropriate use of care, generic prescriptions, and care around diabetes, depression, asthma, COPD, and heart disease.

adult people of color have incomes at or below the Medicaid expansion coverage. In Washington state, Medicaid enrollees have increased by 22 percent since Medicaid expansion was implemented.⁹

Review: The 2013 disparities in care report

Last year for the first time, the Washington Health Alliance was able to report Medicaid data stratified by race, ethnicity, and language. With this data, we were able to identify disparities among 1) patients who receive Medicaid benefits compared with commercially-insured patients and 2) racial and ethnic minority patients within the Medicaid population. Based on our findings, the Alliance created the [*Disparities in Care 2013 Report*](#) which highlighted significant disparities found in the data. Some of the key findings for Medicaid enrollees included:

- Medicaid enrollees receive lower rates of effective care compared to commercially-insured populations across a number of domains, including access to care, diabetes, asthma, depression, and heart disease.
- Quality of diabetes care is lowest among Hispanic/Latino and AI/AN populations enrolled in Medicaid.
- Access to primary care for children and adolescents enrolled in Medicaid is lowest among AI/AN children ages 2 through 6 years old, but varies considerably by race, ethnicity and age.
- For most quality-of-care measures, Asian Medicaid enrollees experience care that is equal to or better than the average Medicaid population.

There has been increased interest around disparities in quality since publication and dissemination of this report. Hospitals, public health agencies, government agencies, academia, and national organizations want to understand these disparities—both what is causing them and what they can do to help bridge gaps in care. To gain insight on perceptions and beliefs of what may be causing these disparities in Washington, the Alliance administered surveys and conducted interviews with key stakeholders throughout the state. The findings provided not only perceptions of contributing factors of disparities, but also the best potential opportunities for intervention. These findings can be found in the “Survey Results and Recommendations” section near the end of this report.

Introducing the 2014 disparities in care report

New to this year’s Disparities in Care report is state-level data. The regional data on Puget Sound in last year’s report created important momentum around disparities and the need for concerted action to address them. Building off the success of that report, the 2014 report includes data on all 39 counties in the state. While the Puget Sound area is a predominantly urban region of the state, the statewide lens offers potential insight into how patients in rural areas of the state may be experiencing care and thus impacting overall state performance.

With this report, the Alliance hopes to inform more targeted strategic efforts to reduce health disparities among minority populations in Washington. The report identifies the biggest gaps in care at a statewide level so stakeholders

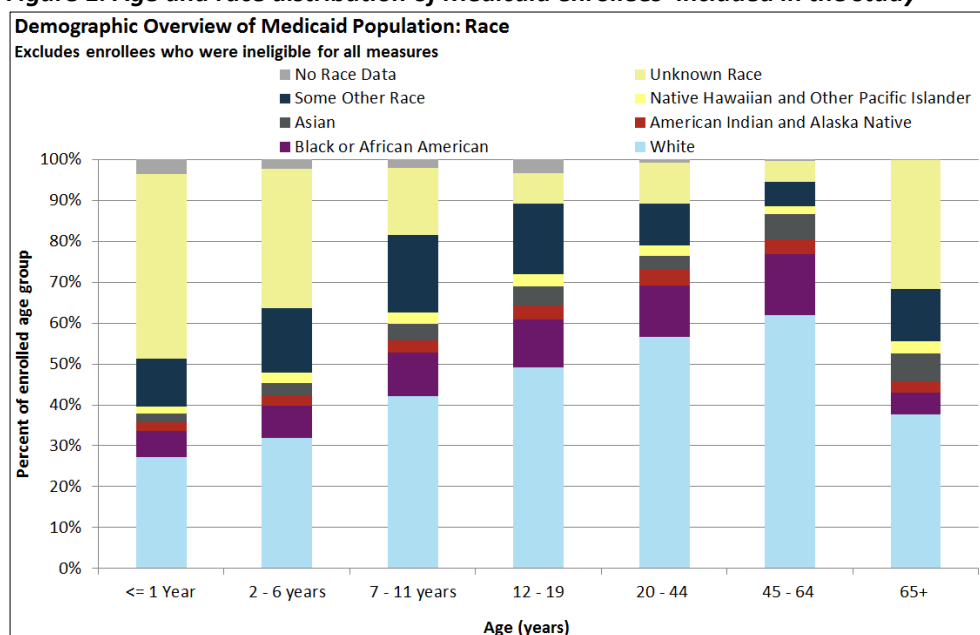
have information they need to know where to allocate resources and pursue interventions. Perhaps even more importantly, we can begin discussing ways to improve our care delivery system, so all patients can receive better quality of care, and ultimately, have better health outcomes.

About the data

The Medicaid population in this report represents those who had full Medicaid insurance benefits in the measurement year of July 1, 2011 to June 30, 2012, and who qualified for Medicaid due to their low income, rather than those eligible due to a disability or high medical need. Medicaid clients who were not eligible for full coverage (such as family planning-only services), those who qualified based on medical need (blind, disabled, medically needy), and/or those who had other payer sources (such as Medicare) were not included in the study. Of the almost 1.2 million Medicaid enrollees in the Alliance's data base, 709,042 met the measure criteria.

Medicaid data limitations include possible underreporting of claims by managed care plans and no reporting of services received outside of Medicaid, such as those from free clinics in the community or tribal clinics. The data has been stratified by race, ethnicity, and language (REL). Findings were not adjusted for differences in age and gender distribution, except for those measures reported by age group and gender. Denominators lower than 160 are suppressed and indicated in the report with an asterisk. A Wilson Score Interval test, using a 95 percent confidence interval, was used to show the statistically significant difference between variables. The Medicaid rate includes all enrollees, including those with partial or incomplete demographic information, as seen in Figure 1.

Figure 1. Age and race distribution of Medicaid enrollees' included in the study



Key Findings

Key finding 1: Medicaid enrollees receive lower rates of appropriate care compared to commercially-insured populations across several quality domains

In Washington state, poverty and where you live matters to your health. Communities in Washington with 20 percent or more of the residents living in poverty, see a 40 percent higher death rate than economically stronger communities with less than five percent of residents living in poverty. Furthermore, lower income Washington adults are more likely to rate their health as fair or poor than those with higher incomes. Almost a third of low-income Washington adults (those who make less than \$25,000 a year), rate their health as fair or poor.¹⁰

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MEDICAID RESULTS

When looking at both Medicaid and commercially-insured populations, Medicaid enrollees receive worse care based on lower rates on many of the measures, particularly around health screenings, access to care, diabetes, asthma, chronic obstructive pulmonary disease (COPD), depression, and heart disease.

HEALTH SCREENINGS AND ACCESS TO CARE

As seen in Figure 2, health screenings and access to care measures whether the enrollee had received a health screening when appropriate or had a visit with a primary care practitioner during the measurement year.

- **Health screenings:** Medicaid performed statistically lower than commercial health plans in adolescent well-care visits and cancer health screening measures. However, in screening for chlamydia, Medicaid is eight percentage points higher than commercial (48 to 40 percent, respectively).
- **Access to care:** In child and adolescent access to primary care, in all age ranges from ages 12 months to 19 years, Medicaid performed lower than commercial. Access for 12 to 19 year olds is particularly concerning; with the Medicaid rate (70 percent) nine percentage points lower than the rate for commercial enrollees (79 percent).

Figure 2. Health screenings and access to care received by Medicaid enrollees compared to commercially-insured populations, 2011-2012

Red= Medicaid rate is significantly* worse than commercial rate; Green= significantly better; Gray=not significantly different.

QUALITY MEASURE	STATEWIDE MEDICAID RATE	STATEWIDE COMMERCIAL RATE
Health screenings		
Adolescent well-care visits – Ages 12-21 yrs	27 %	31 %
Screening for breast cancer - Ages 52–69 yrs	45 %	68 %
Screening for cervical cancer – Ages 21-64 yrs	61 %	69 %
Screening for chlamydia – Ages 16-25 yrs	48 %	40 %
Screening for colon cancer – Ages 51-57 yrs	35 %	51 %
Access to care		
Child & adolescent access to primary care - Ages 12–24 mths	89 %	91 %
Child & adolescent access to primary care - Ages 2–6 yrs	73 %	79 %
Child & adolescent access to primary care - Ages 7–11 yrs	74 %	79 %
Child & adolescent access to primary care - Ages 12–19 yrs	70 %	79 %
Adult access to preventive/ambulatory care - Ages 20–44 yrs	81 %	87 %
Adult access to preventive/ambulatory care - Ages 45–64 yrs	86 %	93 %
Adult access to preventive/ambulatory care - Ages 65+ yrs	89 %	89 %

*Significance was calculated using a chi square test. P-value = 0.05.

DIABETES, ASTHMA, COPD, DEPRESSION AND HEART DISEASE

As seen in Figure 3, disease-specific measures only look at enrollees with the associated disease. In the case of diabetic care, for example, diabetic patients who also saw a provider within the measurement year are included in the measurement criteria.

- **Diabetes:** In diabetes care we see statistically lower rates for Medicaid populations when compared to commercial enrollees for all four measures: Blood sugar (81 to 88 percent), cholesterol testing (67 to 79 percent), eye exam (51 to 60 percent), and kidney disease screening (75 to 81 percent).
- **Asthma and chronic obstructive pulmonary disease (COPD):** Medicaid is statistically lower than commercial for both asthma (84 to 91 percent) and COPD (38 to 44 percent).

- **Depression care:** The biggest disparity is found in depression care with a 17 percentage point difference for both acute (51 to 68 percent) and chronic (34 to 51 percent) depression care.
- **Heart disease:** In cholesterol testing for heart disease patients, Medicaid rates are statistically lower—by 10 percentage points—than similar commercial populations (72 to 82 percent, respectively).

Figure 3. Disease specific care received by Medicaid enrollees compared to commercially-insured populations, 2011-2012

Red= Medicaid rate is significantly* worse than commercial rate; Green= significantly better; Gray=not significantly different.

QUALITY MEASURE	STATEWIDE MEDICAID RATE	STATEWIDE COMMERCIAL RATE
Diabetes		
Blood sugar (HbA1c) test – Ages 18-75 yrs	81 %	88 %
Cholesterol test (LDL-C or bad cholesterol) – Ages 18-75 yrs	67 %	79 %
Eye exam – Ages 18-75 yrs	51 %	60 %
Kidney disease screening – Ages 18-75 yrs	75 %	81 %
Asthma		
Use of appropriate medication – Ages 5-64 yrs	84 %	91 %
Chronic obstructive pulmonary disease (COPD)		
Use of spirometry testing in assessment and diagnosis of COPD - Ages 40+ yrs	38 %	44 %
Depression		
Antidepressant medication (12 Weeks) – Ages 18+ yrs	51 %	68 %
Antidepressant medication (6 Months) – Ages 18+ yrs	34 %	51 %
Heart disease		
Cholesterol test (LDL-C or bad cholesterol) – Ages 18-75 yrs	72 %	82 %
Cholesterol-lowering medication – Ages 18-75 yrs	68 %	72 %

*Significance was calculated using a chi square test. P-value = 0.05.

APPROPRIATE USE OF CARE AND GENERIC PRESCRIPTION DRUGS

As seen in Figure 4, appropriate care measures look at the unnecessary, and sometimes even harmful, overuse of procedures, as well as the use of generic prescription drugs when available and appropriate.

- **Appropriate use of care.** Mixed results are found in the “appropriate use of care” domain, with Medicaid coming in statistically higher in

appropriate use of antibiotics for the common cold, despite having the same 91 percent rate, and the Medicaid rate (85 percent) was lower for the appropriate use of imaging for low back pain than commercially-insured enrollees at 87 percent.

- **Generic prescription drugs.** Medicaid performed statistically higher than commercially-insured enrollees on the use of generic prescription drugs. Notably, a common antacid prescription shows Medicaid rates seven percentage points higher than commercial rates (93 percent compared to 86 percent).

Figure 4. Appropriateness of care received by Medicaid enrollees compared to commercially-insured populations, 2011-2012

Red= Medicaid rate is significantly* worse than commercial rate; Green= significantly better; Gray=not significantly different.

QUALITY MEASURE	STATEWIDE MEDICAID RATE	STATEWIDE COMMERCIAL RATE
Appropriate use of care		
Avoidance of antibiotic treatment in adults w/ acute bronchitis – Ages 18-64 yrs	23 %	24 %
Avoidance of antibiotics for common cold – Ages 18-64 yrs	91 %*	91 %*
Avoidance of X-ray, MRI and CT scan for low back pain – Ages 18-64 yrs	85 %	87 %
Use of generic prescription drugs		
Antacid medication (Proton Pump Inhibitors)	93 %	86 %
Antidepressants	90 %	88 %
Cholesterol-lowering drugs (Statins)	75 %	77 %
Medication for ACE inhibitors or angiotensin II receptor blockers (ARBs) used to treat high blood pressure	93 %	88 %
Medication for attention deficit hyperactivity disorder	68 %	63 %

*Significance was calculated using a chi square test. P-value = 0.05.

*Note: Avoidance of antibiotics for common cold rates for Medicaid=91.4% and commercial=90.8%, are statistically different

Key finding 2: Disparities in access to primary care are greatest for young children, adolescents, and Native American populations

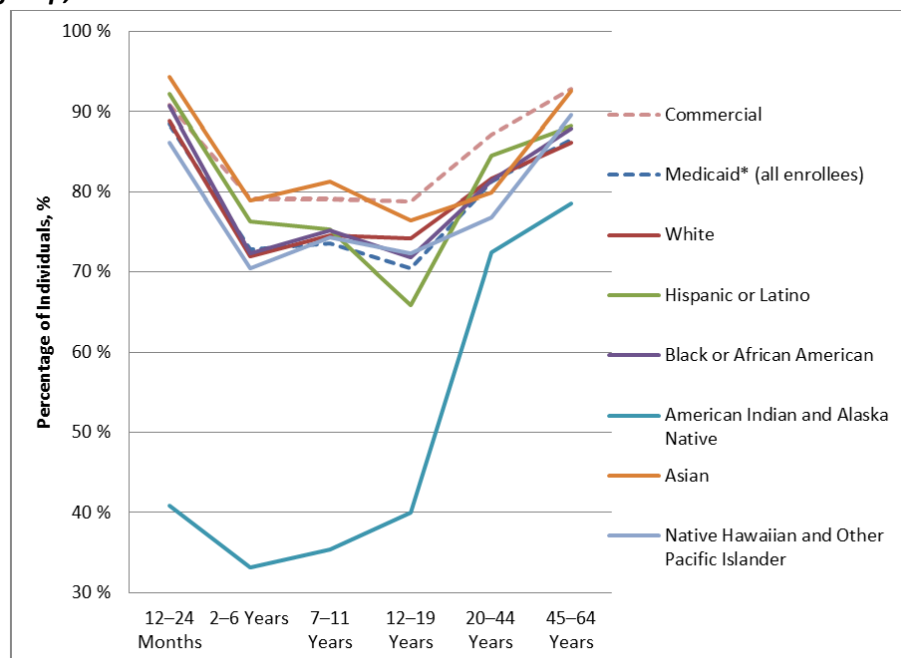
Having adequate access or utilization of care means you are able to visit the doctor regularly, improving overall health and potentially avoiding hospital or emergency room visits. For children and adolescents, preventive visits are important for avoiding illness and promoting healthy behaviors. The American Academy of Pediatrics recommends that children see their doctor for a preventive visit at least every year until age six and then every other year.¹¹

Preventive and well-care visits provide an opportunity to assess health status, provide guidance on health issues, administer health screenings and immunizations, encourage healthy behaviors, and

As seen in Figure 3, rates of access to primary care decreases after infancy until age 19 and then increases through adulthood across all populations and insurance types. Similar to the 2013 findings, children ages 2 to 6 years old experience a steep drop and improve for 7 to 11 year olds. A notable difference in this year's findings is a decrease in rates for teenagers aged 12 to 19 years across all populations, whereas last year rates for teens were similar to 7 to 11 year olds.

When compared to other racial/ethnic groups, access to care rates for American Indian/Alaska Native (AI/AN) populations remained noticeably lower, with larger drops for enrollees from infancy to 19 years olds. Yet, AI/AN adults experience rates of care comparable to other populations. Hispanic enrollees' rates are above the Medicaid average for infancy and adulthood yet for teenagers aged 12 to 19 years old Hispanic enrollees' rates drop noticeably below the Medicaid rate. Rates for Asian enrollees are similar to commercial rates for infants and children but follow closer to the Medicaid rates for adulthood.

Figure 3. Child and adolescent access to primary care and adult access to ambulatory/preventive care among Medicaid enrollees, by racial/ethnic group, 2011-2012



*The Medicaid rate includes all enrollees, including those without available race/ethnicity data.

Key Finding 3: Quality of diabetes care varies among racially and ethnically diverse Medicaid enrollees

The economic and social impact of diabetes is significant. Complications from diabetes include not only heart disease, stroke, and kidney disease, but additional health conditions that can affect daily quality of life, such as high blood pressure, blindness, nervous system disease, lower-extremity amputations, dental disease, and complications of pregnancy. In Washington state, there are approximately 300,000 individuals who have been diagnosed with diabetes, an expected 127,000 people who have undiagnosed diabetes, and almost one million people who have prediabetes.¹² Testing diabetic patients' blood sugar levels is fundamental to the treatment and management of the disease. It is one of the best ways to understand whether diabetes is under control and is crucial for helping to determine how to adjust diabetes medications to ensure they are effective.

As shown in Figure 4, Asian-Americans with diabetes are receiving the best care as demonstrated by key process measures, and African-American and Native Hawaiian/ Pacific Islander enrollees with diabetes are receiving kidney disease screenings at higher rates. In contrast, American Indian/Alaska Native enrollees with diabetes experience lower rates for all four diabetes measures and Hispanic/Latino enrollees with diabetes receive cholesterol testing at a lower rate.

Figure 4. Quality of diabetes care among Medicaid enrollees, 2011-2012*

Red= Medicaid rate is significantly* worse than commercial rate; Green= significantly better; Gray=not significantly different.

DIABETES MEASURE	STATEWIDE MEDICAID RATE	HISPANIC/ LATINO	BLACK OR AFRICAN-AMERICAN	AMERICAN - INDIAN/ ALASKA NATIVE	ASIAN	NATIVE HAWAIIAN / PACIFIC ISLANDER
Blood sugar (HbA1c) test	81 %	81 %	81 %	64 %	86 %	84 %
Cholesterol test (LDL-C or bad cholesterol)	67 %	62 %	64 %	52 %	76 %	69 %
Eye exam	51 %	49 %	51 %	40 %	63 %	56 %
Kidney disease screening	75 %	72 %	78 %	70 %	80 %	81%

*Rates for White enrollees are not included in this Figure as their rates are not significantly different from the regional Medicaid rate for any diabetes measure.

Key Finding 4: Rates for health screenings among Medicaid enrollees vary by type of service and beneficiary race/ethnicity

An important part of preventing illness is receiving appropriate health screenings. Health screenings for cancer are particularly important as cancer is the leading cause of death, responsible for a quarter of all the deaths in Washington between 2009 and 2011.¹³ Furthermore, chlamydia is the most commonly reported sexually transmitted infection in both Washington state and nationally, with the incidence in Washington increasing since 1997.¹⁴

As seen in Figure 5, among cancer screening measures cervical cancer screening rates show the greatest variation, with White and American Indian/Alaska Native populations rating below the state Medicaid results and Hispanic/Latino and African-American enrollees coming in above the Medicaid statewide results. Interestingly, the rate for Hispanic/Latino populations for cervical cancer screenings is at 71 percent, which is not only a higher rate

than the state Medicaid enrollee rate of 61 percent, but also higher than commercially-insured populations at 69 percent.

Figure 5. Cancer screening among Medicaid enrollees, 2011-2012*

Red= Medicaid rate is significantly* worse than commercial rate; Green= significantly better; Gray=not significantly different.

RACIAL/ETHNIC GROUP	CANCER		
	BREAST	CERVICAL	COLON
Medicaid* (All Enrollees)	45%	61%	35%
White	44%	59%	35%
Hispanic or Latino	49%	71%	36%
Black or African American	45%	64%	34%
American Indian and Alaska Native	40%	56%	30%
Asian	56%	61%	33%
Native Hawaiian and Pacific Islander	46%	64%	*

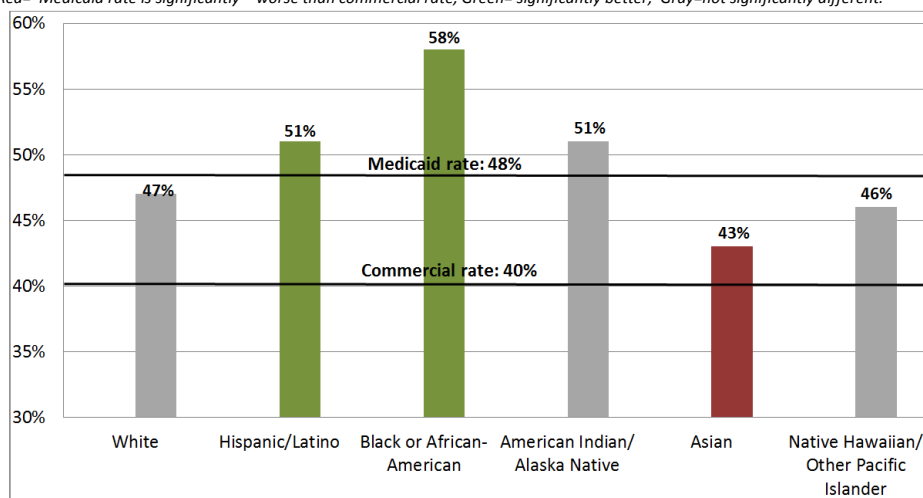
*There were too few patients (less than 160) with the condition of interest to meaningfully report on this measure.

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As seen in Figure 6, African-Americans and Hispanic/Latino Medicaid enrollees receive chlamydia screenings at a higher rate than the state Medicaid enrollee rate, while Asian enrollees receive chlamydia screenings at a lower rate. Interestingly, all race and ethnic populations who are Medicaid enrollees receive chlamydia screenings at a higher rate than commercially-insured enrollees.

Figure 6. Chlamydia Screening among Medicaid enrollees, 2011-2012

Red= Medicaid rate is significantly* worse than commercial rate; Green= significantly better; Gray=not significantly different.



Key Finding 5: American Indian/Alaska Native populations experience the lowest quality of care among Medicaid enrollees across several quality of care domains

American Indian/Alaska Native populations are disproportionately affected by diseases, such as cancer, heart disease, and diabetes.¹⁵ Furthermore, when looking at deaths in Washington state, American Indian/Alaska Native experience the highest age-adjusted death rates when compared to other racial and ethnic groups.¹⁶ This makes the quality of care that they receive that much more important.

NOTE: Medicaid claims data are limited in capturing the full delivery of care for AI/AN populations, since a portion of the care may be provided at tribal health clinics and care delivered at other clinics. This poses a challenge to capture the quality of care being provided and illustrates communication challenges between clinics to provide optimal continuity of care, which is important for disease management, timely prevention screenings, encouraging healthy behaviors, and building a strong relationship with your primary care provider.

As seen in Figure 7, American Indian/Alaska Native populations are receiving lower quality of care when compared to the statewide Medicaid rate in terms of access to care, diabetes, and health screenings. Some of the biggest gaps between the care received by American Indian/Alaska Native populations and Medicaid enrollees as a whole are in access to care, with the largest gap seen in 12-24 month old children. Chlamydia screening results show Medicaid enrollees with a slight three percentage point higher rate than commercially-insured populations yet this difference was not found to be a statistically significant in the findings.

Figure 7. Quality of care received by American Indian/Alaska Native Medicaid enrollees, 2011-2012

Red= Medicaid rate is significantly* worse than commercial rate; Green= significantly better; Gray=not significantly different.

QUALITY MEASURE	AMERICAN INDIAN/ ALASKA NATIVE	Percentage point difference	STATEWIDE MEDICAID RATE
Access to care			
Child and adolescent access to primary care -Ages 12–24mth	41 %	-48	89 %
Child and adolescent access to primary care - Ages 2 – 6 yrs	33 %	-40	73 %
Child and adolescent access to primary care - Ages 7–11 yrs	35 %	-39	74 %
Child and adolescent access to primary care - Ages 12–19 yrs	40 %	-30	70 %

Adult access to preventive/ambulatory care - Ages 20–44 yrs	72 %	-9	81 %
Adult access to preventive/ambulatory care - Ages 45–64 yrs	79 %	-7	86 %
Diabetes			
Blood sugar (HbA1c) test	64 %	-17	81 %
Cholesterol test (LDL-C or bad cholesterol)	52 %	-15	67 %
Eye exam	40 %	-11	51 %
Kidney disease screening	70 %	-5	75 %
Health screenings			
Adolescent well-care visits	18 %	-9	27 %
Screening for breast cancer	40 %	-5	45 %
Screening for cervical cancer	56 %	-5	61 %
Screening for chlamydia	51 %	+3	48 %
Screening for colon cancer	30 %	-5	35 %

Key Finding 6: Quality of care rates for Spanish-speaking Medicaid enrollees suggest room for improvement in diabetes care and health screenings

Language barriers experienced by populations with limited English proficiency have been shown to decrease the use of preventive services and continuity of care, while also increasing the chances of hospital admission and longer hospital stays. Language barriers also limit the adherence to medication and medical advice, which is especially concerning for patients with chronic disease.¹⁷

As seen in Figure 8, the quality of care for Spanish-speaking enrollees varies. Access to primary care for children between 12 months and 11 years old and for adults between 20 and 40 years old was above the state average. Cervical cancer screenings was also above the state average. However, Spanish-speaking teenagers (12 to 19 year olds) experience lower access to care and Spanish-speakers also received less screenings for breast cancer and chlamydia. Spanish-speaking patients with diabetes also experience lower rates for cholesterol testing and kidney disease screening.

Figure 8. Quality of Care received by Spanish-speaking Medicaid enrollees, 2011-2012

Red= Medicaid rate is significantly* worse than commercial rate; Green= significantly better; Gray=not significantly different.

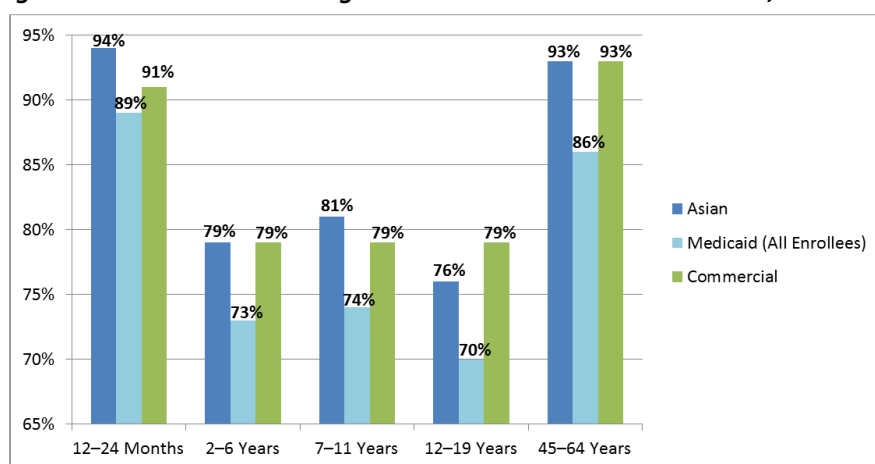
QUALITY MEASURE	SPANISH-SPEAKING MEDICAID ENROLLEES	STATEWIDE MEDICAID RATE
Access to care		
Child & adolescent access to primary care - Ages 12–24 mths	96 %	89 %
Child & adolescent access to primary care - Ages 2 – 6 yrs	82 %	73 %
Child & adolescent access to primary care - Ages 7–11 yrs	76 %	74 %
Child & adolescent access to primary care - Ages 12–19 yrs	62 %	70 %
Adult access to preventive/ambulatory care - Ages 20–44 yrs	87 %	81 %
Diabetes		
Cholesterol test (LDL-C or bad cholesterol)	55 %	67 %
Kidney disease screening	67 %	75 %
Health screenings		
Screening for breast cancer- ages 52-69 yrs	59 %	45 %
Screening for cervical cancer	79 %	61 %
Screening for chlamydia	45 %	48 %

Key Finding 7: Asian American Medicaid enrollees have rates equal or better than the regional Medicaid rate for most quality of care measures

A positive disparity is where a population receives higher quality of care than the overall population. Examining both negative and positive disparities in health care offers valuable lessons in showing the extent of variation and what is possible for those similarly insured. In fact, Asian-American Medicaid enrollees in Washington state not only rate higher on quality of care than the state Medicaid rate, they also out-perform commercially-insured rates in a number of quality of care domains. This finding challenges the commonly-held belief that low-income populations receiving Medicaid automatically experience worse quality of care.

Asian-American enrollees continue to follow commercial trends closely in access to primary care measures, as seen in Figure 9. In particular, access measures for Asian populations in age ranges from 12 to 24 months and 7 to 11 year olds visibly outperform commercial rates. However, Asian teenagers 12 to 19 years of age drop below the commercial rate, though still remain six percentage points above the Medicaid rate for the same age group. What is not captured in these results, however, are the disparities that exist among the diverse Asian ethnic subgroups represented within this population.

Figure 9. Access to care among Asian American Medicaid enrollees, 2011-2012



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In Figure 10, the highlighted rates indicate areas where rates for Asian Medicaid enrollees are higher not only than Medicaid statewide rates but also higher than statewide commercial results. In particular, generic prescription use around antacid medications and attention deficit hyperactivity disorder (ADHD) drugs shows the highest positive disparity, with Asian Medicaid enrollees ranking nine and ten percentage points higher than commercially-insured enrollees.

Figure 10. Quality of care received by Asian American Medicaid enrollees with rates **highlighted when Asian American Medicaid enrollees outperform commercial rates, 2011-2012**

Red= Medicaid rate is significantly* worse than commercial rate; Green= significantly better; Gray=not significantly different.

MEASURE	ASIAN MEDICAID ENROLLEES	STATEWIDE MEDICAID ENROLLEES	STATEWIDE COMMERCIAL ENROLLEES
Diabetes			
Blood sugar (HbA1c) test	86 %	81 %	88 %
Cholesterol test (LDL-C or bad cholesterol)	76 %	67 %	79 %
Eye exam	63 %	51 %	60 %

Kidney disease screening	80 %	75 %	81 %
Prescription drugs			
Antacid medication (Proton Pump Inhibitors)	95 %	93 %	86 %
Antidepressants	93 %	90 %	88 %
Cholesterol-lowering drugs (Statins)	77 %	75 %	77 %
Medication for high blood pressure (Antihypertensives)	81 %	93 %	88 %
Attention deficit hyperactivity disorder drugs (ADHD)	73 %	68 %	63 %
Health screenings			
Adolescent well-care visits	34 %	27 %	31 %
Screening for breast cancer - Ages 52–69 yrs	56 %	45 %	68 %
Screening for chlamydia	43 %	48 %	40 %

Key Finding 8: The differences between the Puget Sound and statewide averages may highlight slight disparities between rural and urban regions in Washington

Although most of the trends in state-level disparities are consistent with what was found in the Puget Sound regional data, there are differences in the state-level data that require more nuanced exploration. For example, state-level results tend to be slightly lower than regional, as seen in Figure 11. These differences suggest disparities between urban and rural counties since the Puget Sound region is more heavily populated than the rest of the state. Such disparities were not clear in the first report because the Puget Sound region is primarily urban, and comparable rural population data was not available.

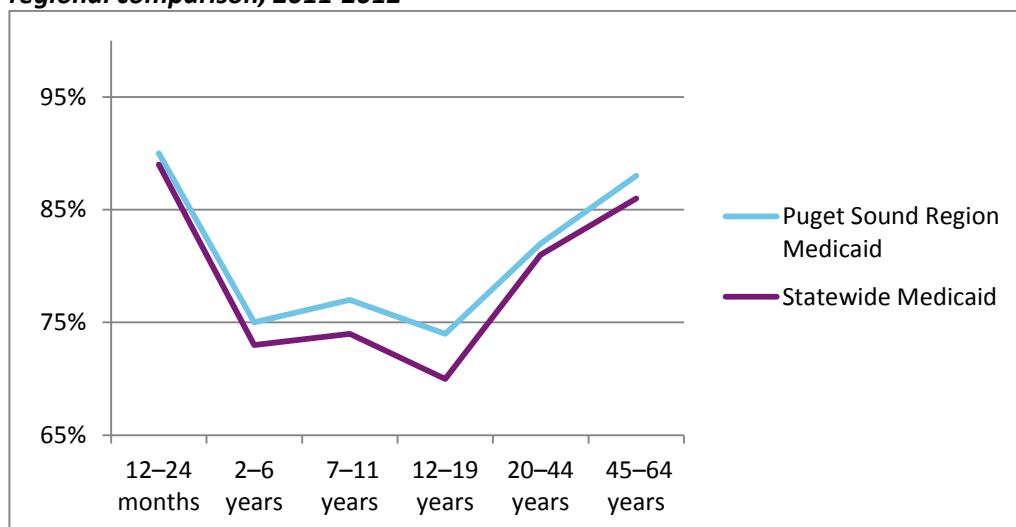
Highlights of state-level results found statistically lower than Puget Sound regional-level rates

- **Access to care.** As seen in Figure 11, lower rates are found in access measures, with the largest difference found in access for 12 to 19 year olds with state results (70 percent) four percentage points lower than regional rate (74 percent).
- **Appropriateness of care.** Results from avoidance of antibiotics for common cold found that state results (91 percent) were three percentage points lower than regional rate (94 percent).

State-level results found statistically higher than Puget Sound regional-level rates

- **Generic prescription drugs.** The only two measures where state-level results showed a higher rate than regional rates is for use of generics for antacid medication (proton pump inhibitors) and angiotensin-converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) used to treat high blood pressure. However, the difference is only slight, with the same (93 percent) or one percentage point difference between statewide (93 percent) and regional results (92 percent).

Figure 11. Child and adolescent access to primary care and adult access to ambulatory/preventive care among Medicaid enrollees, Washington state and Puget Sound (King, Kitsap, Snohomish, Thurston, and Pierce counties) regional comparison, 2011-2012



*Significance was calculated using a chi square test. P-value = 0.05.

Survey and interview findings

BACKGROUND

Following interest from the first Disparities in Care report in 2013, the Alliance wanted to learn more about what may be causing some of the variation in how care is delivered. For that reason, the Alliance conducted a survey and interviews to health equity and physician leaders across the state.

This process was not meant to be scientifically rigorous but rather to get a qualitative sense of what people are seeing and experiencing around disparities in care. The question-and-answer selection options provided to survey participants can be found in Figure 12 below.

Figure 12. Survey questions and answer choices

Participants were asked what the top three factors contributing most to:	1) Disparities between Medicaid and commercially-insured populations 2) Disparities in health screenings 3) Disparities among Alaska Native/American Indian populations 4) Disparities among Spanish-speaking populations
Answer choices for each of the above questions, in order they were presented in the survey, included:	1) Inconvenient clinic locations or limited transportation to clinics 2) Inconvenient clinic hours or long wait times for appointments 3) Limited cultural competency and tailoring of care that may influence how care is provided and perceived 4) Limitations providing care in patients' preferred language 5) Challenges navigating the health care system 6) Limited health literacy (e.g. not understanding instructions for medications, etc.) 7) Limited education and knowledge about specific health conditions 8) High residential mobility (frequent change of residence, making longitudinal care challenging) 9) Environmental stress (social, economic, and physical environments, such as poverty, work demands, family pressures, crime, etc.) 10) Other (please specify)

Interested in seeing the survey and finding out how you would answer the questions?

www.surveymonkey.com/s/alliandedisparities

SURVEY RESULTS

Survey participants expressed difficulty in only selecting three contributing factors, enforcing the belief that issues in disparities in care are indeed extremely complex. Results were similar across all four question categories, showing **environmental stress, cultural competency, navigating the health system, limited health education, and health literacy** as the highest selected contributing factors. Other write-in themes include: provider bias, cultural

insensitivity, access to care for Medicaid patients, inadequate comprehensive/ longitudinal care, cost of care, and previous negative experience with healthcare.

Survey and Interview Methods: Online survey tool. Results include 49 survey participants and four interviewees representing a mix of delivery and policy-level health equity leaders across Washington.

INTERVIEW RESULTS

The Alliance and Finding Answers, a health equity organization based in Chicago, conducted interviews with five key stakeholders to get a better sense of what was found in the survey results. Key take a ways can be seen in Figure 13 below.

Figure 13. Highlights from key stakeholder interviews

Contributing factors for disparities between Medicaid and commercially insured	• Cost of care and competing priorities— Even if an individual has insurance, those in poverty struggle taking time off of work, getting transportation, access to childcare, etc., which are all in competition with health care as potentially higher, more pressing concerns. • One-size-does-not-fit-all—Patient materials and services are often not tailored to a patient's language, cultural framing, age, and perspective on health to provide meaningful information to effectively engage patients.
Contributing factors for disparities among AI/AN populations	• Cultural preferences— AI/AN individual's may prefer to go to tribal health centers for part of their care and receive other care at another facility, making the coordination of quality, longitudinal care challenging between tribal centers and other providers. • Mistrust of the healthcare system—There may be trust concerns that patients have about the health care system. • Diverse tribes— There are many tribes in the northwest, all with different health care perspectives and approaches.
Contributing factors for disparities among Spanish speaking enrollees	• Linguistic barriers and competency —There is not enough Spanish materials and those available may be of low quality. Patients may not understand medical benefits and what may be available to them. • Access to language services—language services need to be easily accessible and available—i.e. not just during the day or at limited locations.
Where should limited resources be placed?	• Preventative care—providing education and outreach to patients to encourage preventative and proactive care. • Cultural Competency training— Resources to organizations to provide cultural competency training and support to providers. • Population health perspective— Communities and health organizations need to be engaged to be part of a comprehensive approach.

Recommendations

The findings in this report demonstrate that racial and ethnic disparities are a problem in Washington State that must be addressed. Modern health care has to successfully balance a mix of standardization and personalization. At first glance the two elements may seem at odds with each other but, in fact, when combined correctly they become a recipe for effective care. A motto commonly used in healthcare delivery organizations, “Every patient. Every time.” is a great example of an organization addressing this mix of standardization and personalization.

Recommendations coming out of the surveys, interviews, and external review process point to some potential early improvement initiatives. As disparities in care are complex and often involve social determinants of health issues that involve a multi-sector approach, the following recommendations are those that the health care sector can directly influence.

Standardization:

- To improve the care for every patient, clinics and medical groups need to focus on standardizing care. Standardization is about ensuring every patient gets the care as expected and when expected. As an example, by ensuring a diabetes care process is in place, all diabetic patients—whether Medicaid or private insurance, or a minority patient—will receive the recommended diabetes care. Putting these processes in place and establishing them as part of the work flow (including support through the electronic health record and daily staff huddles), and then making them part of the culture for all staff within the clinical practice, is key to providing the quality of care for every patient.

Personalization:

- Personalizing care means that care is tailored to a patient’s culture, socioeconomic framing of wellness and healthcare, language, and health literacy levels. Cultural, or “person,” competency is about successfully listening and understanding each patient’s readiness and barriers, and then tailoring the care accordingly. Specific items that health care organizations can focus improvement initiatives on include:
 - Improving cultural competency training for providers and clinic staff
 - Improving care coordination and outreach to minority patients, especially to populations experiencing the poorest outcomes
 - Providing tailored health education materials to a patient’s culture, language, and health literacy level

The hope of the Alliance is that this report provides a call to action that will lead to conversations and effective quality improvement efforts that improves the health of all populations.

Resources

Recommended reading to learn more about disparities in care and health equity issues.

- **A Roadmap and Best Practices for Organizations to Reduce Racial and Ethnic Disparities Care in Health Care:** This article, published in the *Journal for General Internal Medicine*, summarizes current knowledge from the field of disparities intervention research, and provides a 6-step framework for incorporating equity into quality improvement efforts. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC3403142/pdf/11606_2012_Article_2082.pdf

National reports on quality/equality:

- **2013 National Health Care Quality and Disparities Report (AHRQ):** Each year since 2003, the Agency for Healthcare Research and Quality (AHRQ) reports on progress and opportunities for improving health care quality and reducing health care disparities. Available at: <http://www.ahrq.gov/research/findings/nhqrdr/index.html>
- **2013 Health Disparities and Inequalities (CDC):** The Centers for Disease Control and Prevention (CDC) release their second report which looks at recent trends and ongoing variation in health disparities for selected health and social indicators. Available at: <http://www.cdc.gov/minorityhealth/CHDIReport.html>
- **Unequal Treatment (Institute of Medicine):** The report finds that a consistent body of research demonstrates significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable. This research indicates that U.S. racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services. Available at: www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx
- **Crossing the Quality Chasm (Institute of Medicine):** This report from the committee on the Quality of Health Care in America makes an urgent call for fundamental change to close the quality gap. Available at: www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx

National reports on financial impact of racial and ethnic disparities

- **The Economic Burden of Health Inequalities in the United States (The Joint Center for Political and Economic Studies):** This study provides important insight into the financial burden racial disparities are putting on our health care system and society at large. Available at: www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf
- **The State of Urban Health (The Urban League):** Although the complexity of factors contributing to health disparities makes eliminating them costly, this report helps to make the case of why inaction, or action that results in further cuts to important health programs that help to address these disparities, will prove to be much more costly. Available at: www.iamempowered.com/article/2012/12/02/state-urban-health

Understanding the measures

More on the measure specifications used in the Community Checkup and Disparities in Care reports.

Access

- Child and Adolescent Access to Primary Care, for ages 12 months to 19 years: measures the percentage of children ages of [specified age range] who had a visit with a primary care practitioner in the past year.*
- Adult access to preventive/ambulatory care, ages 20 to 64 years: For commercially insured adults ages of [specified age range], this measures those who had a preventive care visit within the past three years. For Medicaid-insured adults ages of [specified age range], this measures those who had a preventive care visit within the past year.*

Appropriate Use of Care

- Avoidance of Antibiotic treatment for Acute Bronchitis: measures the percentage of adults ages 18 to 64 diagnosed with acute bronchitis who were not dispensed an antibiotic prescription on or after three days after diagnosis.*
- Avoidance of Antibiotics for Common Cold: measures the percentage of children ages 18 months to 18 years who went to the doctor for a common cold who were prescribed an antibiotic for three days after the diagnosis.**
- Avoidance of Imaging for Low Back Pain: measures the percentage of patients ages 18 to 50 with a new diagnosis of low back pain who did not have any x-ray, or other imaging study (MRI, CT Scan) in the 28 days after they first visited a health care provider due to low back pain.*

Diabetes Care

- Blood Sugar: measures the percentage of patients ages 18 to 75 diagnosed with diabetes (type 1 and type 2) whose blood sugar was tested using a HbA1c test by a doctor or other health care provider at least once in the one-year measurement period.*
- Cholesterol Test: measures the percentage of patients ages 18 to 75 with diabetes (type 1 and type 2) who had a test for Low Density Lipoprotein cholesterol (LDL-C or "bad" cholesterol) at least once during the one-year measurement period.*
- Eye Exam: measures the percentage of patients ages 18 to 75 diagnosed with diabetes (type 1 and type 2) who had an eye exam at least once in a two-year period or, if there is evidence of eye disease, during a one-year period.*
- Kidney Disease Screening: measures the percentage of patients ages 18 to 75 with diabetes (type 1 and type 2) who had a kidney screening (urine microalbumin) test or were treated for kidney disease (nephropathy) or who have already been diagnosed with kidney disease, at least once during the one-year measurement period.*

Generic Prescription Drugs

- Proton Pump Inhibitors: measures the percentage of prescriptions for antacids to reduce chronic stomach or gastric acid (proton pump inhibitors or PPIs) that were filled with a generic PPI anytime during the one-year measurement period.
- Antidepressants: measures the percentage of prescriptions for antidepressant drugs (all second generation antidepressants) that were filled with a generic antidepressant anytime during the one-year measurement period.
- Cholesterol-Lowering Drugs (Statins): measures the percentage of all prescriptions for cholesterol-lowering drugs (statins) that were filled with a generic drug rather than a brand-name drug anytime during the one-year measurement period.

- Medication for high Blood Pressure (Antihypertensives): measures the percentage of prescriptions for certain antihypertensive drugs (ACE inhibitors and ARBs) that were filled with a generic antihypertensive anytime during the one-year measurement period.
- Attention Deficit Hyperactivity Disorder Drugs: measures the percentage of prescriptions for certain ADHD drugs that were filled with a generic drug rather than a brand name drug anytime during the one-year measurement period.

Asthma

- Asthma: measures the percentage of patients ages 5 to 64 who were identified as having persistent asthma and who were appropriately prescribed long-term controller medication(s) during the measurement year.*

Chronic Obstructive Pulmonary Disease (COPD)

- COPD: measures the percentage of patients ages 40 and older with a new diagnosis of COPD who had appropriate spirometry testing to confirm diagnosis.*

Heart Disease

- Cholesterol Test: measures the percentage of patients ages 18 to 75 who had at least one LDL cholesterol screening test in the year after they were discharged from the hospital for the following heart procedures or conditions: acute myocardial infarction (heart attack), coronary artery bypass graft, percutaneous transluminal coronary angioplasty, or stroke or aneurysm (ischemic vascular disease).*
- Cholesterol-Lowering Medication: measures the percentage of patients ages 18 to 75 with coronary artery disease (heart disease) who had at least one prescription filled to lower cholesterol during a one-year period.*

Depression

- Antidepressant Medication (12 weeks): measures the percentage of patients 18 years and older who were newly diagnosed with depression who were prescribed an antidepressant medication, and remained on an antidepressant during the entire 12 weeks after the diagnosis (i.e. Acute Treatment Phase).*
- Antidepressant Medication (6 months): measures the percentage of patients 18 years and older who were newly diagnosed with depression and who were prescribed an antidepressant medication drug and continued taking an antidepressant for at least 180 days (6 months).*

Health Screenings

- Adolescent Well-Care visits: measures the percentage of adolescents ages 12–21 years who had a well-care visit with a primary care practitioner in the past year.*
- Screening for chlamydia: measures the percentage of women ages 16 to 25 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.*
- Screening for breast cancer: measures the percentage of women ages 52 to 69 who had at least one mammogram to screen for breast cancer during the two-year period measured.*
- Screening for cervical cancer: measures the percentage of women ages 21 to 64 who received one or more Pap tests to screen for cervical cancer within the past three years.*
- Screening for colon cancer: measures the percentage of adults ages 51–57 who had appropriate screening for colon or colorectal cancer.*

* Most measures are modified NCQA HEDIS measures. Detailed specifications can be found at:
http://wacommunitycheckup.org/Media/Default/Documents/community_checkup_technical_specifications.pdf

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Contact Information

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ABOUT THE ALLIANCE

The Washington Health Alliance brings together those who give, get and pay for health care to create a high-quality, affordable system for the people of Washington state. The Alliance is a nonprofit, nonpartisan organization that shares the most reliable data on health care quality and value in the state to help providers, patients, employers and union trusts make better decisions about health care. Through innovative strategies and initiatives, we help the entire health care system—from exam room to board room—focus on improving quality and value. We are committed to being the catalyst for change for the health care system in Washington. The Alliance is one of 16 organizations that are part of the Robert Wood Johnson Foundation’s Aligning Forces for Quality (AF4Q) initiative.

For more about the Alliance:
www.WashingtonHealthAlliance.org

For the Community Checkup report:
www.WACommunityCheckup.org