



Disparities in Care 2013 Report

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Dear Alliance Member,

At the Alliance, we believe that what gets measured, gets managed. That is the principle behind the measures of effective care in the Community Checkup and the analyses we have undertaken in patient experience and resource use. It is also the principle that we have applied to our most recent measurement of health disparities.

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.

Using the Medicaid data from the 2012 Community Checkup, the Alliance has produced reports for medical groups showing their performance on the Community Checkup by race, ethnicity, and language. The purpose of these reports is to help providers who serve the Medicaid population – and not everyone does – better understand potential disparities within their practice. The data can not only help them identify areas of improvement but also look at successes within the practice, to see how they might be duplicated.

As important as we believe these reports are, we also acknowledge their limitations. There are few reliable sources of data on patient race, ethnicity, and preferred language. Fortunately, Medicaid has this data and agreed to share it with the Alliance for this purpose. While we would like to stratify the Community Checkup data for the commercially insured population as well, at present we are unable to do so because enrollee's race, ethnicity, and language are infrequently collected. Still, we believe that the reports based on Medicaid data alone can help advance the community conversation about the need to address disparities. One critical way to address disparities is to assure the use of effective evidence-based practices across all populations

The timing of the reports is fortuitous. There is a great deal of effort to expand access to coverage through the Affordable Care Act, but the health care system has to be prepared to serve the new people entering it. Access to coverage does not necessarily bring access to care, let alone access to quality care. The real work of improving health care remains up to us. Being able to identify variation in quality and price is a critical element of that effort, which is why the Alliance has made transparency a priority.

maryomraciams

Mary McWilliams Executive Director Puget Sound Health Alliance

Background: Disparities in Health Care

Minority patients often experience worse health and receive lower quality of healthcare than White patients Decades of research have conclusively demonstrated that racial and ethnic minorities often experience a higher burden of disability, injury, illness and mortality when compared to White patients.¹ The U.S. Department of Health and Human Services (HHS), in its Healthy People 2020 report, identified serious disparities in health care access and outcomes experienced by racial and ethnic minorities, including cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, immunizations, and infant mortality.²

Disparities have been identified nationwide, and the State of Washington is no exception. For example, recent Centers for Disease Control data found that Hispanic Washington residents were almost half as likely to report having excellent health as White residents. Also, Black residents and American Indian/Alaska Native residents both experienced infant mortality at a rate twice that of the overall population.³

Racial and ethnic disparities are not limited to health status: minority patients often receive lower-quality health care than White patients. Furthermore, these quality differences persist even when insurance status and socioeconomic factors like education and income are taken into account.⁴ The Agency for Healthcare Research and Quality (AHRQ) publishes the annual National Healthcare Disparities Report, which examines the quality of health and health care for minority populations in the United States. The 2012 report reported widespread disparities for minority populations across a variety of quality measures:

- Black patients received worse care than White patients, and Hispanic patients received worse care than non-Hispanic White patients for about 40% of quality measures.
- American Indian/Alaska Native patients (AI/ANs) received worse care than White patients for one-third of quality measures.
- Asian patients received worse care than White patients for about one-quarter of quality measures but better care than Whites for a similar proportion of quality measures.
- Poor and low-income patients received worse care than highincome patients for about 60% of quality measures.⁴

Inequalities in health care are a critical issue, and shifting demographics makes addressing these inequalities all the more urgent: the proportion of Washington's population that was of a racial or ethnic minority increased from 20.6% in 2000 to 27.3% of the population in 2010.⁵ This growth mirrors that of national trends; nationwide, more than 100 million people, or about a third of the population belong to a racial or ethnic minority population, according to 2010 census figures. Furthermore, Census projections estimate that by 2043, 'minority' populations will comprise a majority of the U.S. population.⁵

Disparities are a financial burden on health care systems and present a drain on the economy Racial and ethnic disparities negatively affect the health and well-being of minority patients, but they also represent a significant financial hardship for health care systems. According to a report published by The Joint Center for Political and Economic Studies, 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 just these 3 years, eliminating health disparities for minorities would have reduced direct medical care expenditures by \$229.4 billion.⁶

Poor quality care can often result in substandard preventive care, which leads to more advanced disease that demands more expense.⁴ Tertiary care for diseases such as diabetes and cancer treatments is often significantly more expensive than if there were adequate preventive care, delaying, or even preventing, the onset of advanced disease. The health complications of untreated disease and the moreexpensive treatments it demands ultimately increase overall healthcare costs for individuals, providers, insurers, and governmental agencies.⁴

Beyond healthcare burden, according to the Centers of Disease Control and Prevention (CDC), the human capital costs of disease are significantly higher than direct medical costs. Such costs include the indirect costs of poor health, including absenteeism from the workplace and disability. Moreover, the productivity lost that is related to personal and family health problems costs U.S. employers \$1,685 per employee per year, or \$225.8 billion annually.⁷

The causes of disparities are complex; quality improvement efforts can help Health disparities are undoubtedly complex. Significant social issues contribute to disparities in health and health care, including, environmental factors such as air pollution and water contaminants, neighborhood factors such as food deserts and lack of safe places to play and exercise, institutionalized racism, sexism and homophobia, and differential access to care. Although these challenges are formidable, health care organizations are uniquely positioned to tackle disparities and are starting to build a record of success.⁸ By actively measuring and addressing minority health outcomes, and incorporating disparities reduction into quality improvement efforts,

organizations can reduce or even close disparities gaps while lifting up the quality of care for all patients.

In fact, impending changes in health care policy support the inclusion of equity in quality improvement efforts. In 2010, the Institute of Medicine redefined its definition of quality care, elevating equity to a cross-cutting dimension, essential to all aspects of quality care.¹ In practice, this means that by definition, disparities are evidence of overall low-quality care. Under this model, effective quality improvement efforts must actively identify and address racial and ethnic disparities in care.

Health reforms contained in the Affordable Care Act support the goals of equitable care: the bill mandates the collection of race, ethnicity and language data for federally-funded health care, and other policies offer fresh incentives to prioritize minority health. Accountable Care Organizations, for example, increase a focus on overall population health and link the strengths of the care system with the strengths of the community. Patient-Centered Medical Homes place a high value on the specific needs of each patient, including cultural preferences. With increasing evidence of disparities and a growing body of evidence-based strategies to address these disparities, and health reforms that prioritize equitable care, the time is ripe to address racial and ethnic disparities by incorporating disparities reduction into quality improvement efforts.

Incorporating equity into quality improvement efforts statewide and in the Puget Sound region Drawing upon Medicaid data from the 2012 Community Checkup, stratified by race, language, and ethnicity (REL), the Alliance has developed this report, which highlights evidence of health disparities in the Puget Sound region. Medicaid is an important source of data on health disparities for a community. Nationally, the Medicaid program is the largest provider of insurance coverage for racially and ethnically diverse Americans, covering 67 million Americans, of whom 57% (among the non-elderly) are non-white.⁹ Of the 10.6 million individuals nationally who will be newly eligible for Medicaid (i.e. those residing in states pursuing expansion of the program), 65% are non-white.¹⁰

Unlike other health care purchasers, Medicaid programs have the advantage of being able to link eligibility data, which includes categories for member race, ethnicity, and language, with health service data, providing a rich source of information on where gaps in access and quality are occurring. By focusing on Medicaid enrollees, who by virtue of their eligibility are among the more vulnerable individuals in a community, quality improvement efforts can address not only race/ethnicity, but other indicators of difference – such as socio-economic status – that lead to or exacerbate disparities in a region.

It is the hope of the Alliance that sharing evidence of racial and ethnic disparities in health care in the Puget Sound region will serve as a call to action and a foundation for more targeted and effective quality improvement efforts that incorporate equity, and consequently improve the health of all populations, including the health of racial and ethnic minority populations.

About the Data

The Medicaid population in this report represents those who had full Medicaid insurance benefits in the measurement year of July 1, 2010 to June 30, 2011, lived in the 5 county region (King, Kitsap, Pierce, Snohomish, and Thurston Counties), 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), or those who had other payer sources (such as Medicare) were not included in the study.

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) for the 5 county region. Findings were not adjusted for differences in age and gender distribution, except for those measures reported by age group and gender. A Wilson Score Interval test, using a 95% confidence interval, was used to show the statistically significant difference between variables. The Medicaid regional rate includes all enrollees, including those for whom there is no available race, ethnicity, or language information, as indicated by "No Race Data" 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 effective care compared to commercially-insured populations across a number of quality of care domains.

- Health Screenings. As shown in Table 1, the differences between Medicaid and commercial rates are among the highest for health screenings than for other domains of care, specifically for screening for breast cancer (ages 52-69), cervical cancer, and colon cancer, for which Medicaid rates are low; (rates range from 38% to 68%). Medicaid rates are also lower than commercial insurance for adolescent wellcare visits. Notably, Medicaid outperforms commercial insurers in chlamydia screening, with Medicaid 10 percentage points higher than the commercial rate (50% versus 40%).
- Access to Care. Adult Medicaid enrollees experience better access to preventive/ambulatory care with increasing age, while children's access tends to decrease with increasing age. Notably, the trend of decreasing access for children with increasing age is present in the commercial market as well. While Medicaid rates for enrollees of very young age (infants) or old age (older than 65 years) are on par with commercial rates, Medicaid enrollees in between the life span toddlers, adolescents, teenagers, adults, and older adults less than 65 years of age receive compromised access to preventive/ ambulatory care relative to their commercially-insured counterparts. Notably, the lowest performing areas of access for Medicaid enrollees are *Child and Adolescent Access to Primary Care for Ages 2–6 Years* and *Ages 12 19 years*, with Medicaid rates of 78% and 79%, respectively.
- **Diabetes:** Medicaid rates on all four of the diabetes measures blood sugar testing, cholesterol testing, eye exam, and kidney disease screening are lower than commercial rates. The biggest difference is in the area of cholesterol testing, for which the Medicaid rate is 70% and the commercial rate is 80%.
- Asthma, COPD, and Depression. When compared to patients with commercial insurance, Medicaid enrollees are not receiving the same level of care for measures of asthma, COPD, and depression care. Notably, the Medicaid rates for depression medication treatment at 12 weeks and 6 months are17 and 16 percentage points lower than commercial rates, respectively.
- **Heart Disease:** Medicaid performance for heart disease measures are mixed, with Medicaid performing on par or better than commercial insurers for use of cholesterol-lowering medication and beta blockers, respectively, but worse for cholesterol testing (75% Medicaid, 83% Commercial).
- Generic Prescription Drugs. This is a domain in which Medicaid consistently performs better than commercial insurers. Generic prescribing rates for all measured drug types are higher among Medicaid enrollees than among patients with commercial insurance. Differences are particularly pronounced for the use of generics for cholesterol lowering drugs (91% Medicaid, 74% Commercial) and blood pressure medications (91% Medicaid, 7.3% Commercial).
- **Appropriateness of Care.** Medicaid also performs well and on par with commercial insurers-- around appropriateness of care for the common cold and lower back pain. Medicaid and commercial rates for the appropriateness of care for acute bronchitis are both the same at a notably low 23%.

Table 1: Rates of effective care received by Medicaid enrollees compared to commercially-insured populations

Red= Medicaid rate is significantly* worse than commercial rate; Green= Medicaid rate is significantly better than commercial rate; Grey= Medicaid and commercial rates are not significantly different.

Quality Measure	Medicaid Rate	Commercial Rate	
Health Screenings			
Adolescent Well-Care Visits	36 %	40 %	
Screening for Breast Cancer - Ages 52–69	50 %	76 %	
Screening for Cervical Cancer	68 %	78 %	
Screening for Chlamydia	50 %	40 %	
Screening for Colon Cancer	38 %	61 %	
Access to Care			
Child & Adolescent Access to Primary Care - Ages 12–24 Mths	91 %	94 %	
Child & Adolescent Access to Primary Care - Ages 2–6 Yrs	78 %	85 %	
Child & Adolescent Access to Primary Care - Ages 7–11 Yrs	81 %	85 %	
Child & Adolescent Access to Primary Care - Ages 12–19 Yrs	79 %	84 %	
Adult Access to Preventive/Ambulatory Care - Ages 20–44 Yrs	85 %	93 %	
Adult Access to Preventive/Ambulatory Care - Ages 45–64 Yrs	90 %	96 %	
Adult Access to Preventive/Ambulatory Care – Ages 65+ Yrs	92 %	92 %	
Diabetes			
Blood Sugar (HbA1c) Test	84 %	89 %	
Cholesterol Test (LDL-C or Bad Cholesterol)	70 %	80 %	
Eye Exam	63 %	67 %	
Kidney Disease Screening	78 %	86 %	
Asthma			
Use of Appropriate Medication	86 %	92 %	
COPD			
Use of Spirometry Testing in Assessment & Diagnosis of COPD	43 %	55 %	
Depression			
Antidepressant Medication (12 Weeks)	53 %	70 %	
Antidepressant Medication (6 Months)	37 %	53 %	
Heart Disease			
Beta Blockers	80 %	78 %	
Cholesterol Test (LDL-C or Bad Cholesterol)	75 %	83 %	
Cholesterol-Lowering Medication	72 %	76 %	
Generic Prescription Drugs			
Antacid Medication (Proton Pump Inhibitors)	92 %	85 %	
Antidepressants	94 %	88 %	
Cholesterol-Lowering Drugs (Statins)	91 %	74 %	
Medication for High Blood Pressure (Antihypertensives)	91 %	73 %	
Pain Relief (Non-Steroidal Anti-Inflammatory Drugs)	98 %	92 %	
Appropriate Use of Care			
Avoidance of Antibiotic Treatment in Adults w/ Acute Bronchitis	23 %	23 %	
Avoidance of Antibiotics for Common Cold	93 %	92 %	
Avoidance of X-ray, MRI and CT Scan for Low Back Pain	85 %	86 %	

*Significance was calculated using a two-sample z test. P-value = 0.05.

KEY FINDING #2: Among Medicaid enrollees, access to primary care for children and adolescents varies considerably by age category and by race/ethnicity.

As shown in Figure 2, across all populations – commercially-insured and Medicaid-insured – rates of access to primary care among children decreases with age after infancy. Children ages 2-6 years old experience a steep drop in meeting the generally accepted guidelines for preventive care, while there is a notable improvement in primary care for children 7-11 years. While access dips again between the ages of adolescence (7-11 years) and teenage years (12-19 years) for most Medicaid enrollees, access for teenagers seems to increase slightly and/or stay the same for American Indian/Alaska Natives and Native Hawaiian/Other Pacific Islanders.

Notably, Asian American enrollees receive primary care at rates closer to those of commercially-insured populations, while American Indian/Alaska Natives, Native Hawaiian/Other Pacific Islanders, and Hispanic/Latino enrollees experience the lowest rates of access to primary care. The biggest need for improvement lies in the American Indian/Alaska Native population, which receives primary care at rates nearly 50 percentage points lower than other enrollees.

Overall, with the exception of the Hispanic/Latino rate at infancy and the Asian rate at infancy and ages 2-6 years, all rates for racially/ethnically diverse enrollees are significantly below the overall Medicaid regional rate (note: those enrollees for whom race/ethnicity information were not available were still included in the Medicaid rate, which might contribute to the higher Medicaid rate than is otherwise apparent through the race/ethnicity breakout).





*The Medicaid rate also includes enrollees for whom there was no available race/ethnicity data.

KEY FINDING #3: Quality of diabetes care varies among racially/ethnically diverse Medicaid enrollees, with rates pointing to opportunities for improvement among Hispanic/Latino and American Indian/Alaska Native populations.

As shown in Table 2, among Medicaid enrollees, Asian Americans are receiving the best diabetes care, as their rates are on par or higher than the rate for the overall Medicaid population. Medicaid Native Hawaiian/Other Pacific Islanders and African-Americans are also doing reasonably well, with significantly higher rates for kidney disease screening compared to the overall Medicaid population.

By contrast, the lowest rates of diabetes care are experienced among Hispanic/Latinos and American Indian/Alaska Natives, who experience worse care for every diabetes measure in comparison to the overall Medicaid population. While American Indian/Alaska Natives show need for significant improvement around blood sugar testing, cholesterol testing, and eye exams, the biggest areas of disparity for Hispanic/Latino enrollees lie in cholesterol testing and kidney disease screening.

Table 2: Quality of Diabetes Care among Racially/Ethnically diverse Medicaid enrollees*

Red = significantly worse than Medicaid regional rate for all enrollees; Green = significantly better than Medicaid regional rate for all enrollees; Grey = no significant difference.

Diabetes Measure	Medicaid Rate	Hispanic/ Latino	Black or African- American	American Indian/Alaska Native	Asian	Native Hawaiian/ Other Pacific Islander
Blood Sugar (HbA1c) Test	84 %	81 %	83 %	75 %	88 %	85 %
Cholesterol Test (LDL-C or Bad Cholesterol)	70 %	61 %	67 %	62 %	78 %	71 %
Eye Exam	63 %	61 %	60 %	54 %	67 %	66 %
Kidney Disease Screening	78 %	73 %	82 %	76 %	82 %	85 %

*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, with room for improvement around adolescent well-care visits, in particular.

Adolescent Well-Care Visits: Rates for several enrollees -- White, Hispanic/Latino, African-American, and American Indian/ Alaska Native-- were significantly below that of the overall Medicaid population for this measure. Comparatively, Asians and Native Hawaiians/Other Pacific Islanders received adolescent well-care visits at higher rates (41% and 36%, respectively), as shown in Figure 3.





*The Medicaid rate also includes enrollees for whom there was no available race/ethnicity data.

Other significant differences among racial/ethnic groups were found for the following health screenings:

- Breast Cancer (ages 52-69): Asians enrollees are screened at a higher rate (58%) than the general Medicaid population (50%).
- Cervical Cancer: White and American Indian/Alaska Native enrollees have lower rates (65% and 63%, respectively) than the general Medicaid population (68%). Hispanic enrollees have the highest rates (76%).
- **Chlamydia:** Asian Americans have the lowest rates (39%), while African-Americans and American Indian/ Alaska Native have the higher rates (60% and 57%, respectively).

KEY FINDING #5: American Indian/Alaska Native populations experience the lowest quality of care among Medicaid enrollees across several quality of care domains.

As shown in Table 3, one of the biggest areas of disparity for the American Indian/Alaska Native population is around children's access to primary care, where rates for the overall Medicaid population are almost double those of American Indian/Alaska Native children in the toddler (ages 2-6 years), adolescent (ages 7-11 years), and teenage (12-19 years) years. In the areas of infant access to primary care and adult access to preventive/ambulatory care -- where Medicaid enrollees are otherwise performing on par or better than commercially-insured populations – American Indian/ Alaska Natives experience poor rates as well.

All measures of diabetes care, except kidney screenings, show significantly lower rates for American Indian/Alaska Natives. No other racial/ethnic group is scoring as poorly on as many diabetes measures.

Use of generic drugs for antidepressants is higher among Medicaid enrollees than commercially-insured populations, yet American Indian/Alaska Natives have the lowest rates within the Medicaid population. Notably, however, the rate for American Indian/Alaska Natives (89%) is still higher than the commercial rate (88%).

Among health screening measures, adolescent well-care visits and cervical cancer screening have lower scores for American Indian/Alaska Natives than for overall Medicaid population. Notably, the only measure for which American Indian/Alaska Natives score higher than the overall Medicaid population is chlamydia screening (57% versus 50%).

Table 3: Quality of Care Received by American Indian/Alaska Native Medicaid enrollees

ned – significantly worse than mealedia regional rate for all enrollees, or	een – significantiy better than mealeara regi			
Maagura	American Indian/Alaska	All Medicaid		
weasure	Native Medicaid Enrollees	Enrollees		
Access to Care				
Child and Adolescent Access to Primary Care - Ages 12–24 mos.	58 %	91 %		
Child and Adolescent Access to Primary Care - Ages 2 – 6 yrs.	40 %	78 %		
Child and Adolescent Access to Primary Care - Ages 7–11 yrs.	51 %	81 %		
Child and Adolescent Access to Primary Care - Ages 12–19 yrs.	51 %	79 %		
Adult Access to Preventive/Ambulatory Care - Ages 20–44 yrs.	81 %	85 %		
Adult Access to Preventive/Ambulatory Care - Ages 45–64 yrs.	85 %	90 %		
Diabetes				
Blood Sugar (HbA1c) Test	75 %	84 %		
Cholesterol Test (LDL-C or Bad Cholesterol)	62 %	70 %		
Eye Exam	54 %	63 %		
Generic Prescription Drugs				
Antidepressants	89 %	94 %		
Health Screenings				
Adolescent Well-Care Visits	24 %	36 %		
Screening for Cervical Cancer	63 %	68 %		
Screening for Chlamydia	57 %	50 %		

Red = significantly worse than Medicaid regional rate for all enrollees; Green = significantly better than Medicaid regional rate for all enrolle

KEY FINDING #6: Quality of care rates for Spanish-speaking Medicaid enrollees suggest room for improvement in the domains of access, diabetes care, depression, acute bronchitis care, and health screenings.

As shown in figures 4 and 5, measures that show the biggest negative disparity for Spanish-speakers are use of *Antidepressant Medication (12 Weeks) and Cholesterol Testing,* for which the overall Medicaid rate is 42 and 14 percentage points higher than the Spanish-speaking rate, respectively.





Additionally, access to care is lower among Spanish-speaking adolescents and teenagers than non-Spanish speaking enrollees in the same age group, as shown in Table 4. Notably, rates for Spanish speakers of other ages—children under age 6 and adults ages 20-44, are higher than for the general Medicaid population.

Measures of biggest positive disparity include Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis and Screening for Cervical Cancer, for which Spanish-speaking rates are 29 and 15 percentage points higher than that of the overall Medicaid population, respectively. Notably, while the cervical cancer screening rate is high for Spanish-speakers, rates for other types of health screenings – adolescent well-care and chlamydia – lag behind.

Red = significantly worse than Medicala regional rate for all enrollees, Green = significantly better than Medicala regional rate for all enrollees				
Measure	Spanish-Speaking Medicaid	All Medicaid Enrollees		
Access to Care				
Child & Adolescent Access to Primary Care - Ages 12-24 mths	96 %	91 %		
Child & Adolescent Access to Primary Care - Ages 2 – 6 Yrs	83 %	78 %		
Child & Adolescent Access to Primary Care - Ages 7–11 Yrs	76 %	81 %		
Child & Adolescent Access to Primary Care - Ages 12–19 Yrs	68 %	79 %		
Adult Access to Preventive/Ambulatory Care - Ages 20–44 Yrs	88 %	85 %		
Appropriate Use of Care				
Avoidance of Antibiotic Treatment, Adults w/Acute Bronchitis	52 %	23 %		
Depression				
Antidepressant Medication (12 Weeks)	11 %	55 %		
Diabetes				
Cholesterol Test (LDL-C or Bad Cholesterol)	56 %	70 %		
Kidney Disease Screening	67 %	78 %		
Health Screenings				
Adolescent Well-Care Visits	34 %	36 %		
Screening for Cervical Cancer	83 %	68 %		
Screening for Chlamydia	45 %	50 %		

Table 4: Quality of Care Received by Spanish-speaking Medicaid enrollees

KEY FINDING #7: Asian Medicaid enrollees have rates on par or better than the regional Medicaid rate for most quality of care measures.

As shown in Table 5, Asian enrollees performed significantly better than the overall Medicaid population, across several measures. The measures with the biggest differences are Appropriateness of Care: *Avoidance of X-ray, MRI and CT scan for Low Back Pain,* Heart Disease: *Cholesterol-Lowering Medication,* and Health Screenings: *Adolescent Well-Care Visits* and *Screening for Breast Cancer - Ages 52–69.*

There are only two measures, *Screening for Chlamydia* screening and *Adult Access to Preventive/Ambulatory Care - Ages 20–44,* for which Asian enrollees experienced worse care than Medicaid enrollees overall. Notably, rates for American Indian/Alaska Natives and Native Hawaiians/Other Pacific Islanders are also significantly lower than the overall Medicaid population for adult access.

Table 5: Quality of Care Received by Asian Medicaid enrollees

Red = significantly worse than Medicaid regional rate for all enrollees; Green = significantly better than Medicaid regional rate for all enrollees

Measure	Asian	All Medicaid Enrollees		
Access to Care				
Child and Adolescent Access to Primary Care - Ages 2 – 6 yrs.	80 %	78 %		
Adult Access to Preventive/Ambulatory Care - Ages 20–44 yrs.	82 %	85 %		
Adult Access to Preventive/Ambulatory Care - Ages 45–64 yrs.	93 %	90 %		
Appropriate Use of Care				
Avoidance of X-ray, MRI, and CT Scan for Low Back Pain	96 %	85%		
Diabetes				
Blood Sugar (HbA1c) Test	88 %	84 %		
Cholesterol Test (LDL-C or Bad Cholesterol)	78 %	70 %		
Generic Prescription Drugs				
Antacid Medication (Proton Pump Inhibitors)	97 %	92 %		
Antidepressants	98 %	94 %		
Cholesterol-Lowering Drugs (Statins)	96 %	91 %		
Health Screenings				
Adolescent Well-Care Visits	41 %	36 %		
Screening for Breast Cancer - Ages 52–69	58 %	50 %		
Screening for Chlamydia	39 %	50 %		
Heart Disease				
Cholesterol-Lowering Medication	86 %	72 %		

Citations

- 1. Smedley B.D., Stith A.Y., & Nelson A.R. (2003). Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Washington: Institute of Medicine.
- 2. Healthy People 2020. (2012). U.S. Department of Health and Human Services 2012. Available at: www.healthypeople.gov/2020/about/DisparitiesAbout.aspx
- 3. Governor's Interagency Council on Health Disparities. (2010). State Policy Action Plan to Eliminate Health Disparities.
- 4. National Healthcare Disparities Report 2012. (2013). AHRQ Publication, No. 13-0003. Rockville, MD. Agency for Healthcare Research and Quality.
- 5. U.S. Census Bureau. (2010) State & County Quickfacts: Washington State. Available at: http://quickfacts.census.gov
- 6. LaVeist, T.A., Gaskin, D.J., & Richard, P. (2009). The Joint Center for Political and Economic Studies. The Economic Burden of Health Inequalities in the Unites States.
- 7. Center for Disease Control and Prevention. (2012). Behavioral Risk Factor Surveillance System. National Center for Health Statistics. Atlanta, GA.
- 8. Chin M.H., Clarke A.R., Nocon R.S., et al. (2012). A roadmap and best practices for organizations to reduce racial and ethnic disparities in healthcare. Journal of General Internal Medicine; 27(8):992-1000.
- 9. Kaiser Family Foundation, State Health Facts. (2010). *Distribution of the Nonelderly with Medicaid by Race/Ethnicity*, states (2009-2010).
- 10. Kaiser Family Foundation, Disparities Policy. (2013). *Impact of Current State Medicaid Expansion Decisions on Coverage by Race and Ethnicity*, 8450.

Resources

1. A Roadmap and Best Practices for Organizations to Reduce Racial and Ethnic Disparities 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.

www.ncbi.nlm.nih.gov/pmc/articles/PMC3403142/pdf/11606 2012 Article 2082.pdf

2. National reports on Quality/Equality:

- a. 2012 National Health Care Quality and Disparities Report (AHRQ): Each year since 2003, the Agency for Healthcare Research and Quality (AHRQ) has reported on progress and opportunities for improving health care quality and reducing health care disparities.
 www.ahrq.gov/research/findings/nhqrdr/nhdr12/nhdr12_prov.pdf
- b. 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. www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx
- c. **Crossing the Quality Chasm:** 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. www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx

3. The financial impact of racial and ethnic disparities:

- d. The Economic Burden of Health Inequalities in the United States (The Joint Center for Political and Economic Studies): This study, commissioned by the Joint Center for Political and Economic Studies and carried out by leading researchers from Johns Hopkins University and the University of Maryland, provides important insight into how much of a financial burden racial disparities are putting on our health care system and society at large. The researchers examined the direct costs associated with the provision of care to a sicker and more disadvantaged population, as well as the indirect costs of health inequities such as lost productivity, lost wages, absenteeism, family leave, and premature death. www.jointcenter.org/hpi/sites/all/files/Burden_Of_Health_FINAL_0.pdf
- e. **The State of Urban Health (The Urban League): This report helps to make the case for why although** the complexity of factors contributing to health disparities makes eliminating them costly, 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. Therefore, allocating the appropriate amount of financial resources to reduce racial/ethnic disparities in health is not only a moral imperative, but also a fiscally responsible one. www.iamempowered.com/article/2012/12/02/state-urban-health

About the Alliance

The Puget Sound Health Alliance <<u>www.pugetsoundhealthalliance.org</u>>, an Aligning Forces for Quality Community, is a nonprofit made up of those who provide, pay for and use health care, working to improve quality of care at a price more people can afford. More than 165 organizations have joined the Alliance, including The Boeing Company, Starbucks, Puget Sound Energy, Washington State Health Care Authority, King County and many other employers, physician groups, hospitals, consumer organizations, unions, health plans, pharmaceutical companies, associations and others. A cornerstone of the Alliance work is the Community Checkup, a regional report to the public comparing the performance of clinics and hospitals for basic measures of quality care in the Puget Sound area <<u>www.wacommunitycheckup.org</u>>.

Contact Information

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