Presentation Outline

- The Importance of Addressing Health Equity
- Health Equity Leads to Better Outcomes
- Racial and Ethnic Health Disparities Do Exist
- The ASO and PCMH Practices as True Partners
- Action Oriented Team Approach at the Practice Level
- Strategies to Engage Patients toward the Highest Level of Health
- National and Connecticut Data Assists Providers Develop a Team Approach that Drives Outcomes

The Importance of Addressing Health Equity

- The key in addressing health equity is to eliminate care disparities by delivering best care practices to improve care for ALL patients.
  - The United States spends 2.8 trillion dollars on healthcare costs each year, gaps in care and outcome differences among groups of people within comparative cohorts is a contributing factor
  - Chronic diseases drive more than 75% of care expenses in this country today and is growing at an alarming rate for all ethnic groups
  - Data shows *outcome differences* among various racial and ethnic groups, that make up the American population, is very real and highly significant

The Importance of Addressing Health Equity

- Purpose for today's webinar is to approach topics of Health Equity at a macro level and examine care differences both nationally and specific to the Connecticut population.
  - Providers play a vital role in influencing patients' healthy behavior choices
  - This webinar will allow us to look at ways we can improve care for everyone and reduce disparities in care delivery as well as key outcomes

Health Equity Leads to Better Outcomes

Health Equity in Healthcare Delivery and Management

- Important leaders striving to achieve success in Health Equity include:
  - Institute of Medicine of the National Academies
  - NCQA – Measuring Quality, Improving Healthcare
  - U.S. Department of Health & Human Services

Health Equity Leads to Better Outcomes

- Health Equity is:
  - The absence of avoidable differences in health status
  - Obtaining the highest level of health for all people
  - The ability to provide “Culturally Responsive” care
  - Communicating in a way that people understand
  - Being an active listener

Cultural Competence

- Cultural Competence is:
  - Learning about people's beliefs and heritage
  - Providing respect and preserving dignity
  - Accommodating preferred languages
  - Modifying communication to level of health literacy

Cultural Competence (Cont.)

- Matching the patient with a healthcare team based on racial, ethnic and/or language characteristics
- Using educational materials to meet individual needs
- Establishing culturally/linguistically appropriate goals
- Tracking process to achieve quality outcomes

Racial and Ethnic Disparities Do Exist

Racial and Ethnic Disparities Do Exist

According to the National Healthcare Disparities Report (NHDR) from the Agency for Healthcare Research and Quality (AHRQ), racial and ethnic minorities, individuals with limited English proficiency, low-income individuals, and those with less education face more barriers to care, and receive poorer quality of care when they seek care.

Racial and Ethnic Disparities Do Exist

- Race/Ethnicity
- Age/Gender
- Cultural/Religious Beliefs
- Behavioral Health/Chronic Medical Conditions/Disabilities
- Sexual Orientation
- Socio-Economic Status
- Urban/Rural

The ASO and PCMH Practices as True Partners

The ASO and PCMH Practices as True Partners

It Takes a Village…

CMAP providers and the Department of Social Services' Administrative Service Organization (ASO) work together as strong partners in the delivery of quality care

- Using resources to promote Patient-Centered care
- Accessing clinical programs to promote wellness and stabilize chronic disease
- Promoting Medical Home to ensure patient engagement and adherence to care plan
- Utilizing data collection and analysis to drive care delivery

ASO Resources

- **Intensive Care Management**
  - Taking care of those that are the sickest and with the greatest disability
  - Registered Nurses in the field visiting patients and collaborating with providers
  - Assisting providers with their patient's plan of care
- **Specialized Intensive Care Management**
  - *Healthy Beginnings* focuses on minimizing the risk of pregnancy complications
  - *Healthy Airways* and *Healthy Living with Diabetes* provide condition specific chronic disease education and support

ASO Resources (Cont.)

- **Transitional Care**
  - Confirming that discharge plans from acute care are seamless
  - Assuring timely primary care follow up occurs
  - Working with providers on medication adherence
- **Community Support Services**
  - Face to face visits in patient's homes
  - Empowering patients by identifying and obtaining community based social support
  - Teaching patients to advocate for themselves

ASO Resources (Cont.)

- **Community Practice Transformation**
  - Leading practices to achieve Medical Home recognition
  - Supporting a team concept that promotes self-management
  - Providing Health Equity education that **WORKS** to close gaps in care

- **Regional Network Management**
  - Dedicated team implementing a single analytical tool that combines elements of care opportunities, risk and provider effectiveness to improve patient assessment
  - Providing reports that identify trends to improve practice patterns

Action Oriented Team Approach at the Practice Level

An Action-Oriented Team Approach Fills in the Gaps

- Create an organizational climate, culture, policies and training on Health Equity in your practice setting

  *NCQA 1.G.5-7 ,6.C.1-4

- Collect and use demographic data to identify and reduce health disparities among your patients

  *NCQA 1.F.1-2, 2.A.3-5, 2.C.2-3, 6.C.3, 6.A.4

- Have language services and translated materials appropriate for your patient population

  *NCQA 1.F.3-4

***Fulfills NCQA Standards**

An Action-Oriented Team Approach Fills in the Gaps (Cont.)

- Focus on patient-centered communication skills that promote shared decision making

  *NQA 1.F.3-4, 1.G.7, 4.A.1-2

- Identify and refer your patients to community-based resources for support

  *NCQA 4.B.1

- Assess patient experiences of care

  *NCQA 6.B.1-4, 6.C.3, 6.A.4

***Fulfills NCQA Standards**

Culturally and Linguistically Appropriate Services (CLAS) Standards in Healthcare

- *The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care* (the *National CLAS Standards*) are intended to advance health equity, improve quality, and help eliminate health care disparities

- The aim is to provide a blueprint for individuals and health care organizations to implement culturally and linguistically appropriate services to best serve the nation's increasingly diverse communities

www.thinkculturalhealth.hhs.gov

Culturally and Linguistically Appropriate Services (CLAS) Standards in Healthcare

- In 2000, the Office of Minority Health published the first *National Standards for Culturally and Linguistically Appropriate Services in Health Care* (National CLAS Standards), which provided a framework for all health care organizations
- In fall of 2010, the Office of Minority Health launched the National CLAS Standards Enhancement Initiative
- This was done in order to revise the Standards to reflect the past decade's advancements, expand their scope, and improve their clarity to ensure understanding and implementation

Culturally and Linguistically Appropriate Services (CLAS) Standards (Cont.)

- State agencies have embraced the importance of cultural and linguistic competency. A number of states have proposed or passed legislation pertaining to cultural competency training for one or more segments of their state's health professionals
- Health inequities in our nation are well documented, and the provision of culturally and linguistically appropriate services (CLAS) is one strategy to help eliminate health inequities
- By tailoring services to an individual's culture and language preference, health professionals can help bring about positive health outcomes for diverse populations

Culturally and Linguistically Appropriate Services (CLAS) Standards (Cont.)

- Principal Standard:

  Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

  - Governance, Leadership, and Workforce
  - Communication and Language Assistance
  - Engagement, Continuous Improvement, and Accountability

Strategies to Engage Patients Toward the Highest Level of Health …

True engagement improves population health

Promotion of Patient Engagement

- Assess satisfaction on access and quality of care
  (Utilize surveys, individual interviews, suggestion boxes)

- Hire staff that culturally and linguistically represent the practice's population

- Promote cultural competence through staff training

Promotion of Patient Engagement (Cont.)

- Improve shared decision making by developing a true partnership with patients
- Provide education that is tailored to the patient
- Collect, stratify, learn and work towards best practice using data collected for quality improvement

Patients belong in the "Driver's Seat"

- Patient experience and engagement are critical to improving healthcare
- Patient satisfaction (leads to provider satisfaction)
- Utilizing CLAS standards fosters shared decision making
- Appropriate levels of education lead to informed choice
- Partnering empowers patients and caregivers
- Patients need to "Own their Own Health"
- Self-management includes wellness participation

Stereotyping

- May occur without conscious awareness
- Learn to recognize your own personal biases and reactions
- Realize all people have a right to quality care
- Enhance empathy toward others
- Focus on the unique qualities of a patient
- Enhance your skills to promote positive emotions
- Improve your abilities to build relationships

Motivational Interviewing ~ Across Cultures

- Effects change
- Uses collaboration instead of confrontation
- Facilitates trust and moves toward wellness
- Draws out or evokes a person's own ideas
- Empowers a person to be responsible for their own decisions (Autonomy)

Motivational Interviewing ~ Communication

- Acknowledge emotions, feelings, and other non-verbal messages
- Ask open-ended questions
- Look for clarification to verify that your message is heard
- Encourage patients to talk about themselves
- Be an active listener:
  - Lean forward
  - Focus on the patient's face
  - "Tell me more about yourself"
  - Maintain an open body posture (face the client)

National and Connecticut Data Assists Providers Develop a Team Approach that Drives Outcomes

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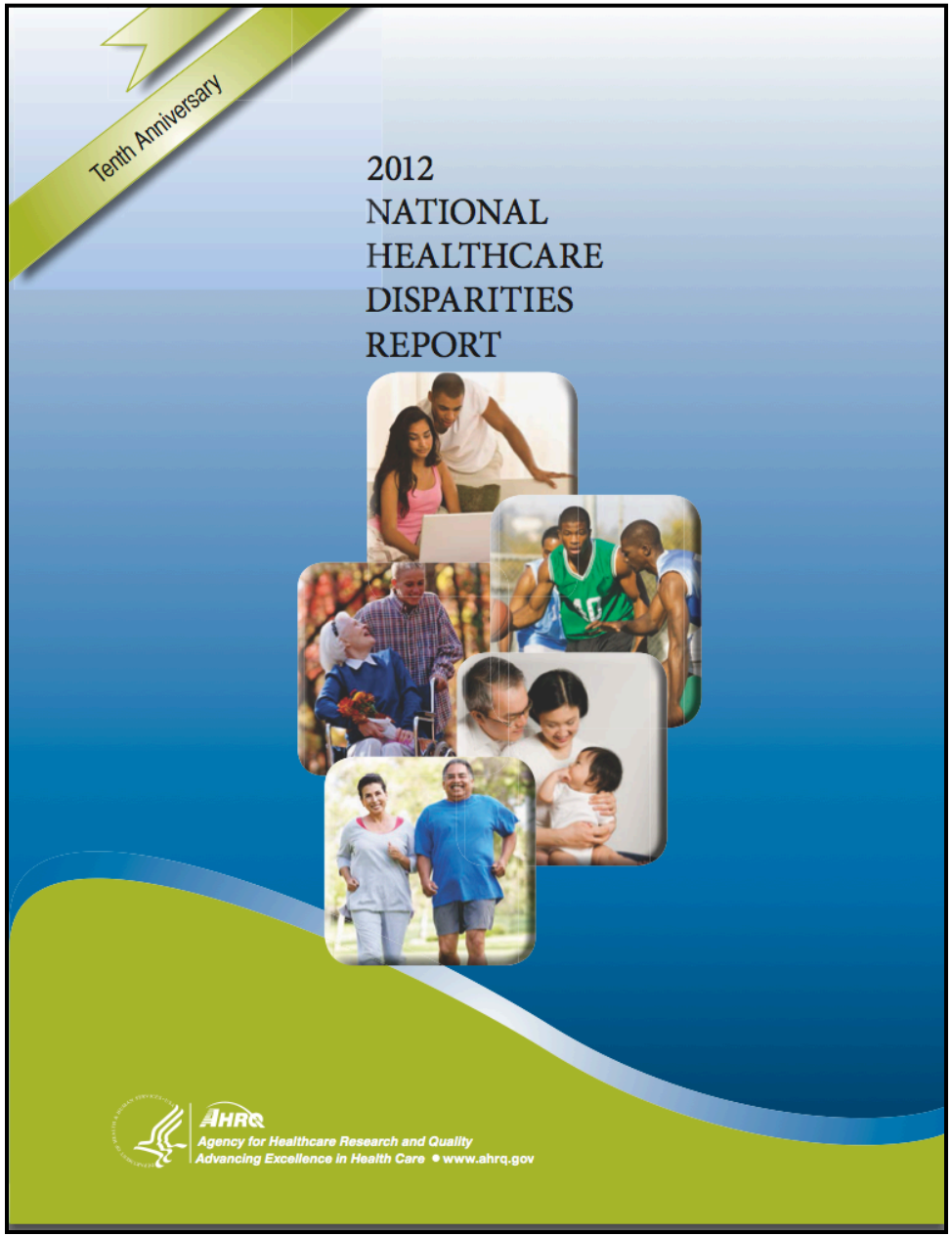
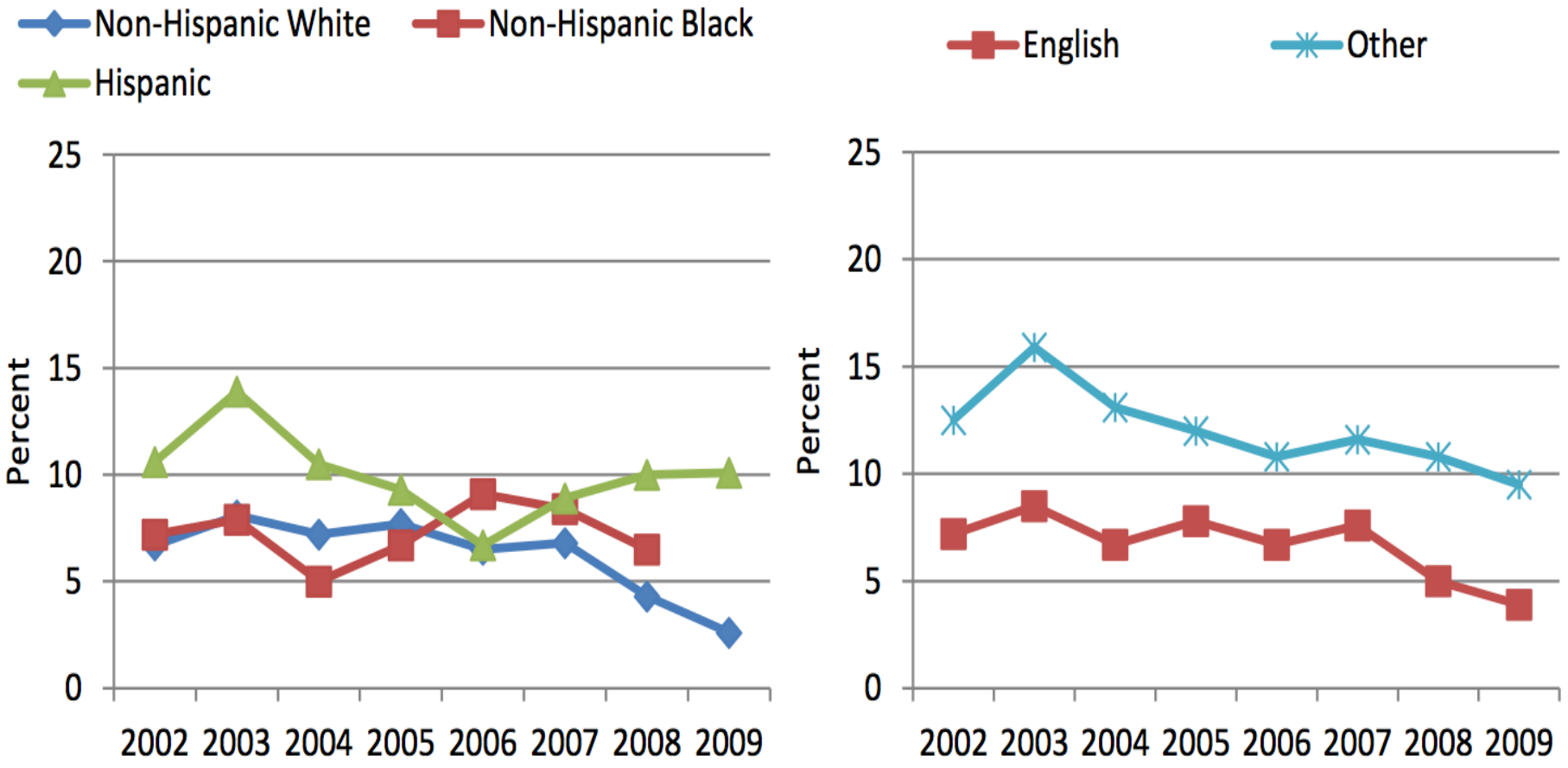
2012 National Healthcare Disparities Report


Tenth Anniversary
2012
NATIONAL
HEALTHCARE
DISPARITIES
REPORT
AHRQ
Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

Percentage of access measures with worse outcomes than Whites	2008-2010
For Blacks	33% (7 of 21 measures)
For Hispanics	71% (15 of 21 measures)

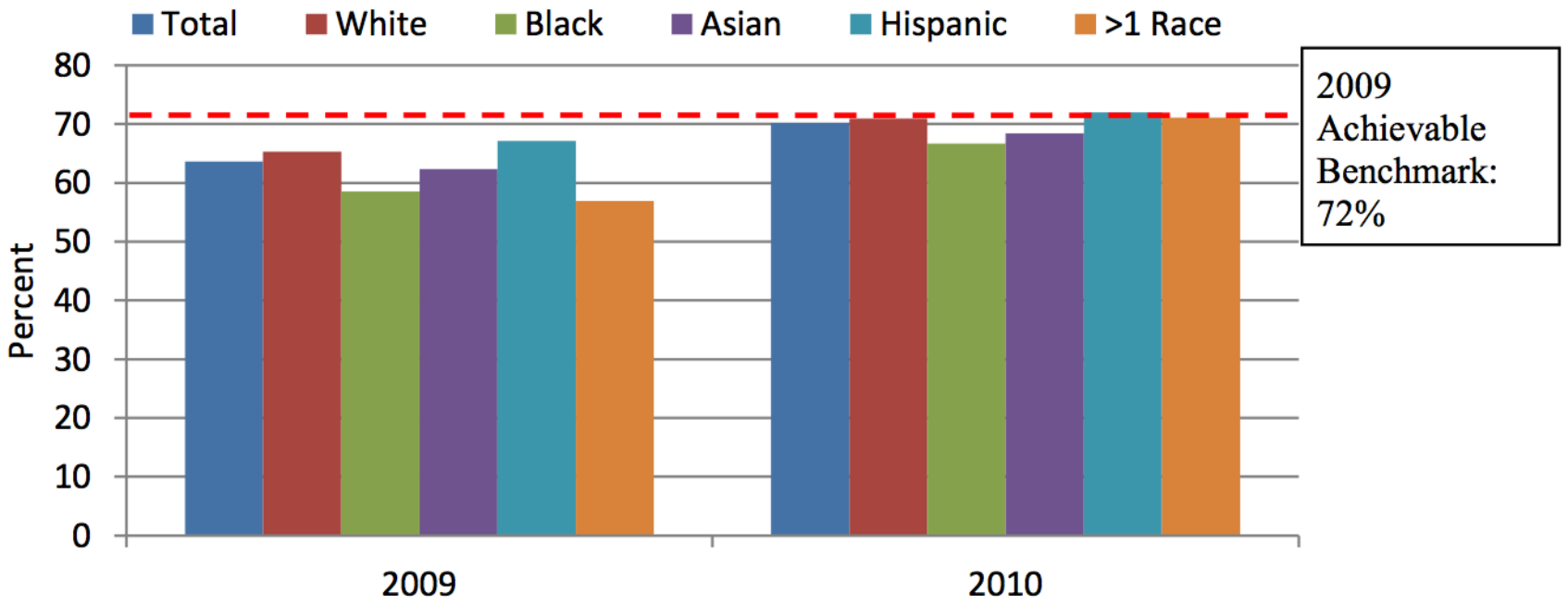
Percentage of outcome measures with worse outcomes than Whites	2008-2010
For Blacks	43% (82 of 191 measures)
For Hispanics	42% (75 of 178 measures)

Figure 4.2. Children who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted, by ethnicity and language spoken at home, 2002-2009



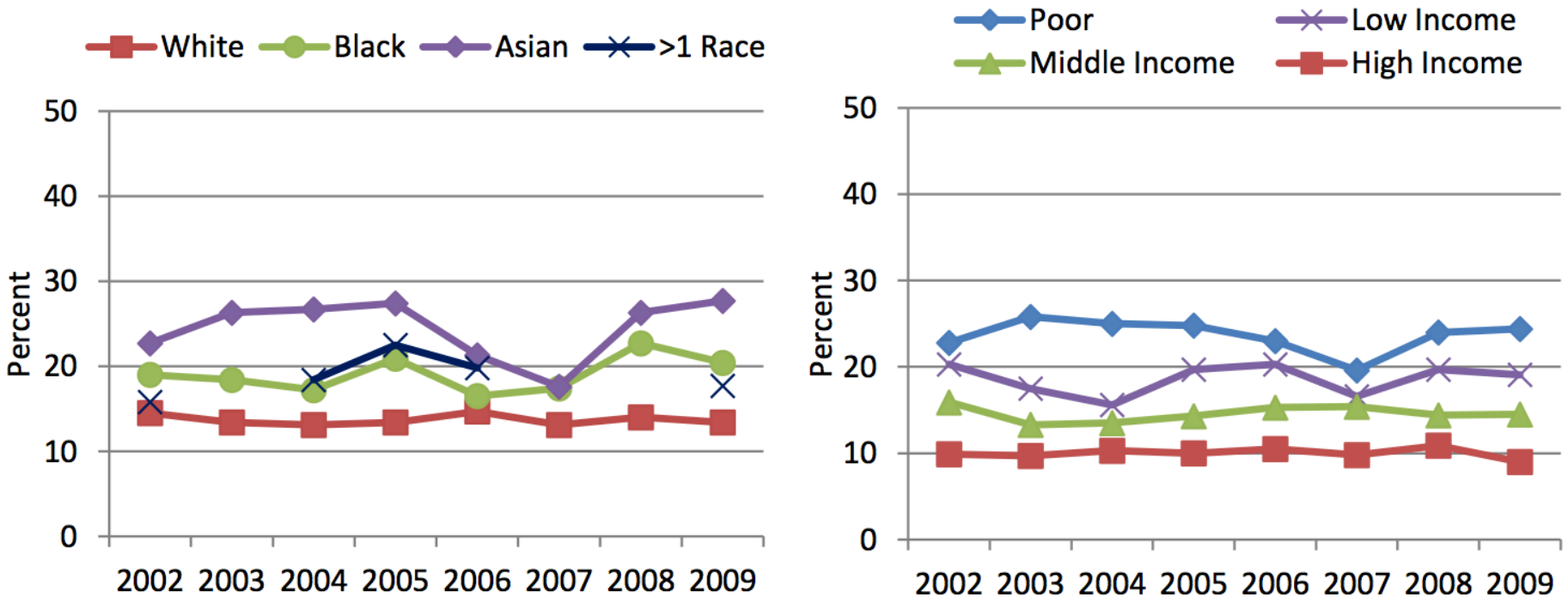
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2009.
Denominator: Civilian noninstitutionalized population under age 18.
Note: For this measure, lower rates are better. The 2009 data for non-Hispanic Blacks did not meet criteria for statistical reliability, data quality, or confidentiality.

Figure 2.28. Children ages 19-35 months who received the 4:3:1:3:3:1:4 vaccine series, by race/ethnicity, 2009-2010



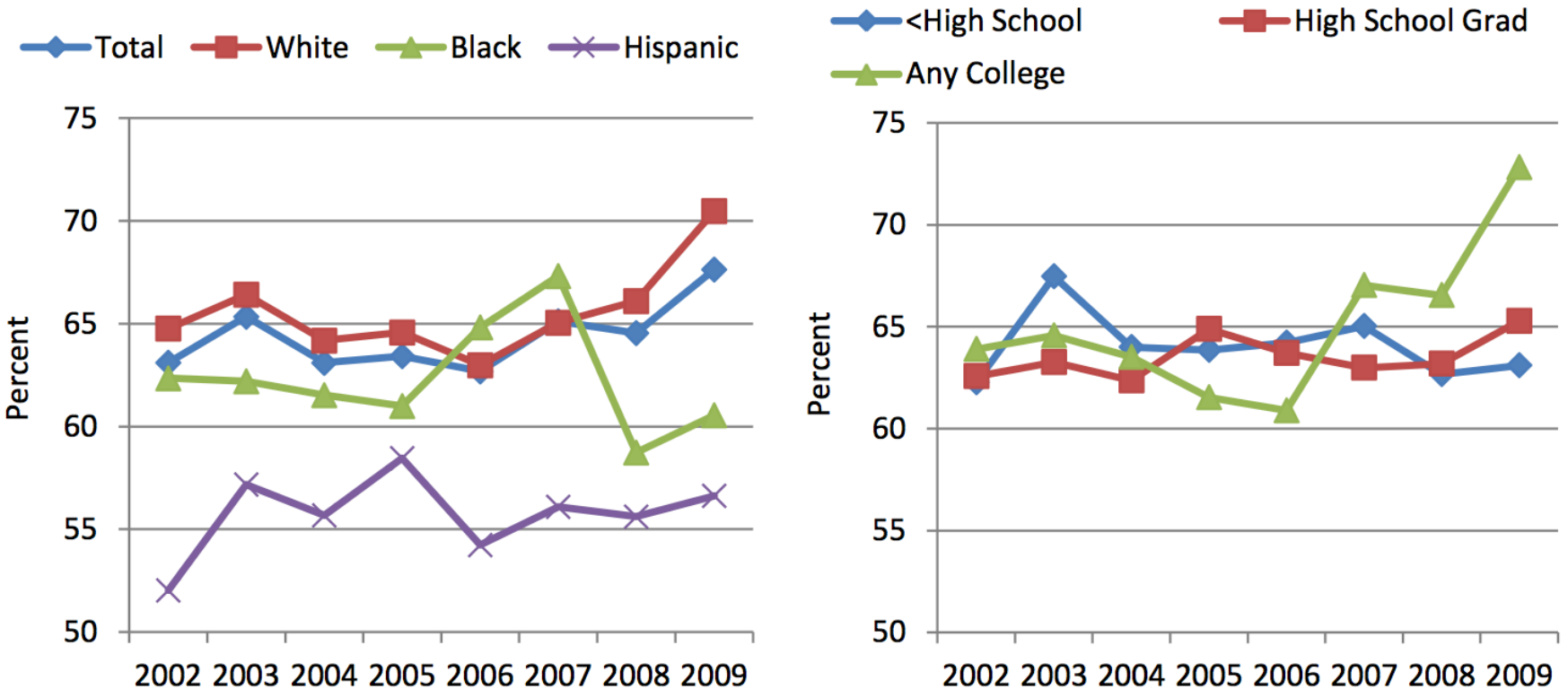
Source: Centers for Disease Control and Prevention, National Center for Health Statistics and National Center for Immunization and Respiratory Diseases, National Immunization Survey, 2009-2010.
Denominator: U.S. civilian noninstitutionalized population ages 19-35 months.
Note: White, Black, Asian, and more than one race are non-Hispanic; Hispanic includes all races.

Figure 4.1. Adults who needed care right away for an illness, injury, or condition in the last 12 months who sometimes or never got care as soon as wanted, by race and income, 2002-2009



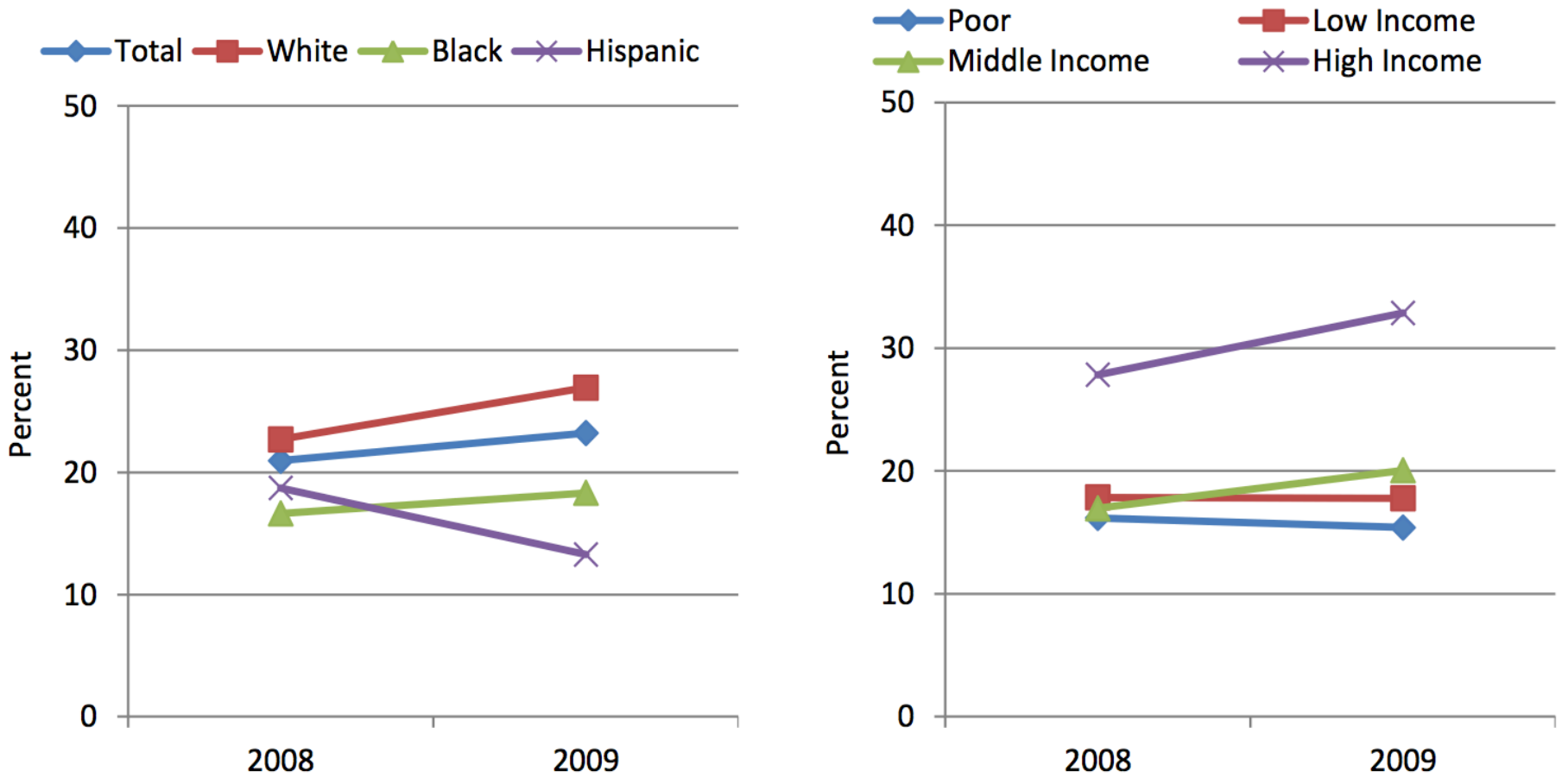
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2009.
Denominator: Civilian noninstitutionalized population age 18 and over.
Note: For this measure, lower rates are better. Data were insufficient for this analysis for multiple race in 2003, 2007, and 2008.

Figure 2.46. Adult current smokers with a checkup in the last 12 months who received advice from a doctor to quit smoking, by race/ethnicity and education 2002-2009



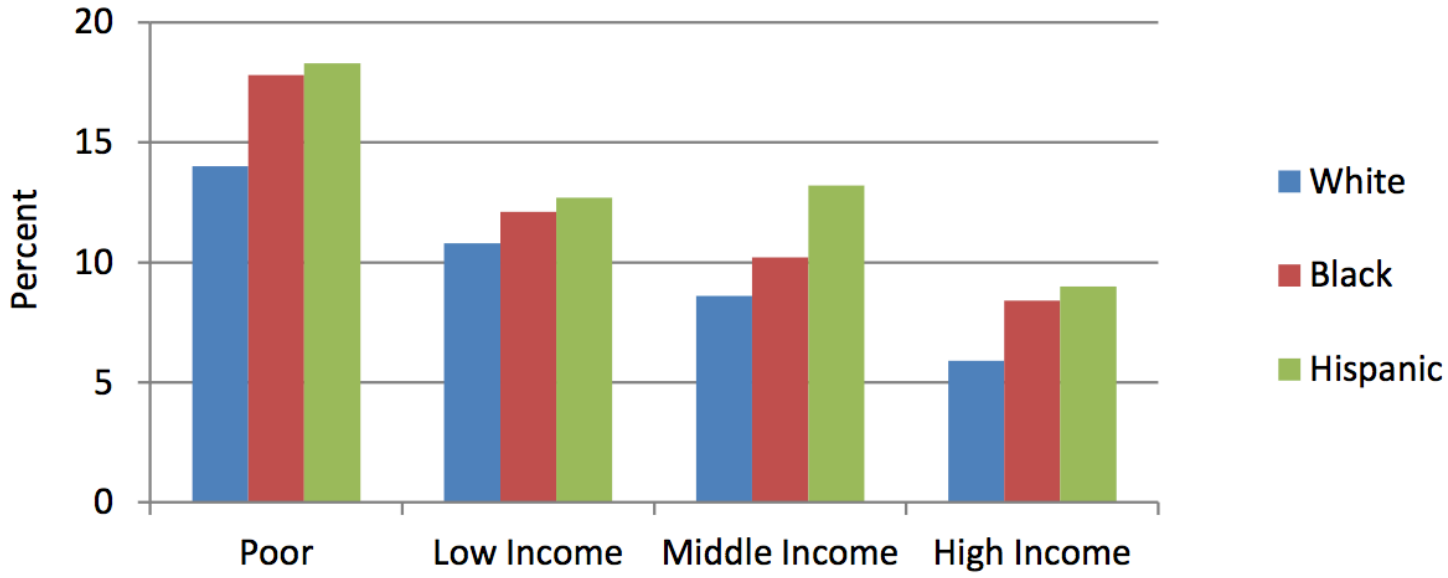
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2009.
Denominator: Civilian noninstitutionalized adult current smokers who had a checkup in the last 12 months.
Note: Estimates are age adjusted to the 2000 U.S. standard population using three age groups: 18-44, 45-64, and 65 and over. White and Black are non-Hispanic. Hispanic includes all races.

Figure 2.18. Adults age 40 and over with diagnosed diabetes who reported receiving four recommended services for diabetes in the calendar year (2+ hemoglobin A1c tests, foot exam, dilated eye exam, and flu shot), by race/ethnicity and income, 2008-2009



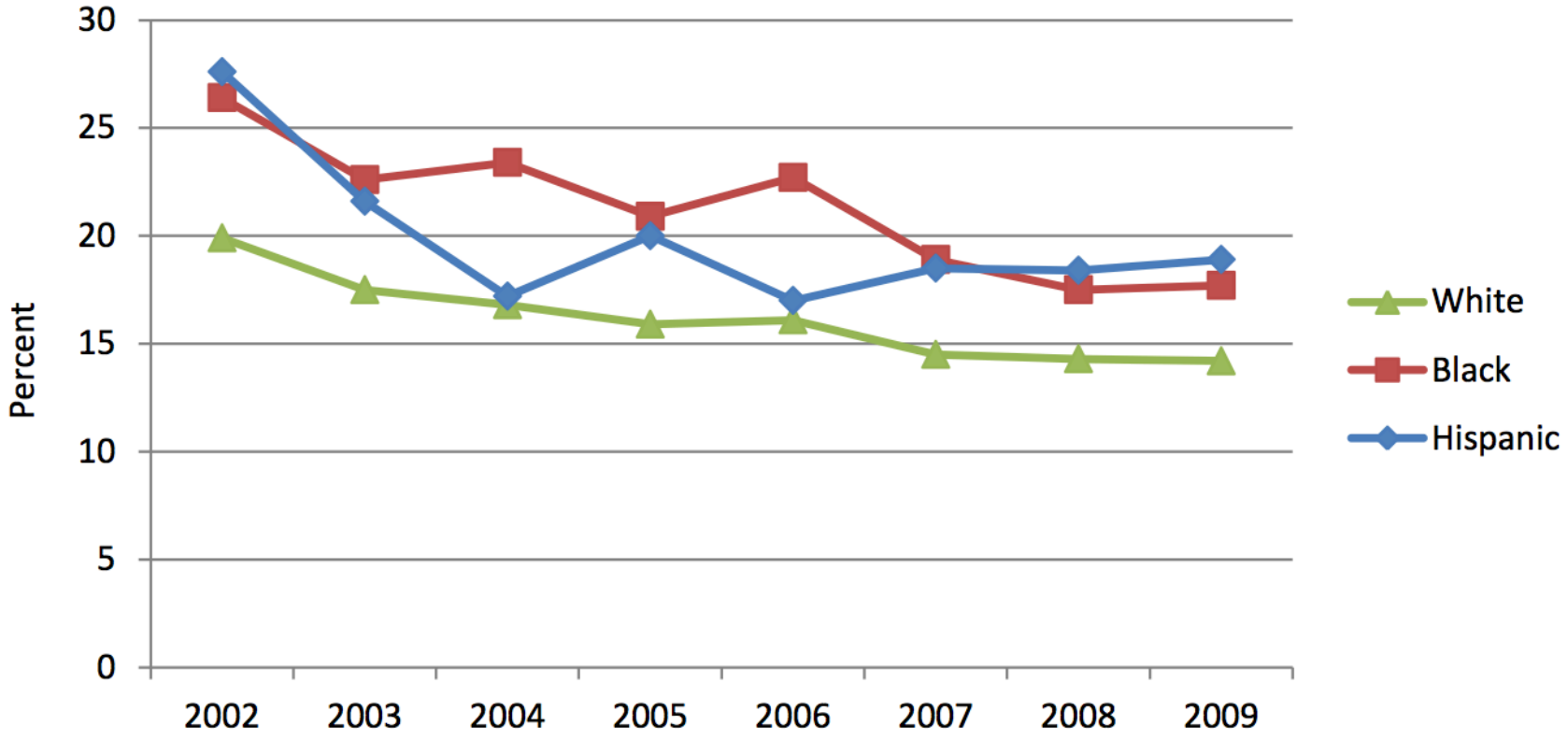
Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2008-2009.
Denominator: Civilian noninstitutionalized population with diagnosed diabetes, age 40 and over.
Note: Data include people with both type 1 and type 2 diabetes. Rates are age adjusted to the 2000 U.S. standard population. White and Black are non-Hispanic; Hispanic includes all races.

Figure 5.2. Adult ambulatory patients who reported poor communication with health providers, by race/ethnicity, stratified by income, 2009



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2009.
Denominator: Civilian noninstitutionalized population age 18 and over.
Note: For this measure, lower rates are better. White and Black are non-Hispanic. Hispanic includes all races. Patients who report that their health providers *sometimes* or *never* listened carefully, explained things clearly, showed respect for what they had to say, or spent enough time with them are considered to have poor communication.

Figure 5.8. Adults with a usual source of care whose health providers sometimes or never asked for the patient's help to make treatment decisions, by race/ethnicity, 2002-2009



Source: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey, 2002-2009.
Denominator: Civilian noninstitutionalized population with a usual source of care.
Note: For this measure, lower rates are better.

Data on next seven slides are from the 2009 Connecticut Report

Figure 36. Percent of Women Receiving Late or No Prenatal Care, Connecticut Residents, by Race or Ethnicity, 2002–2006

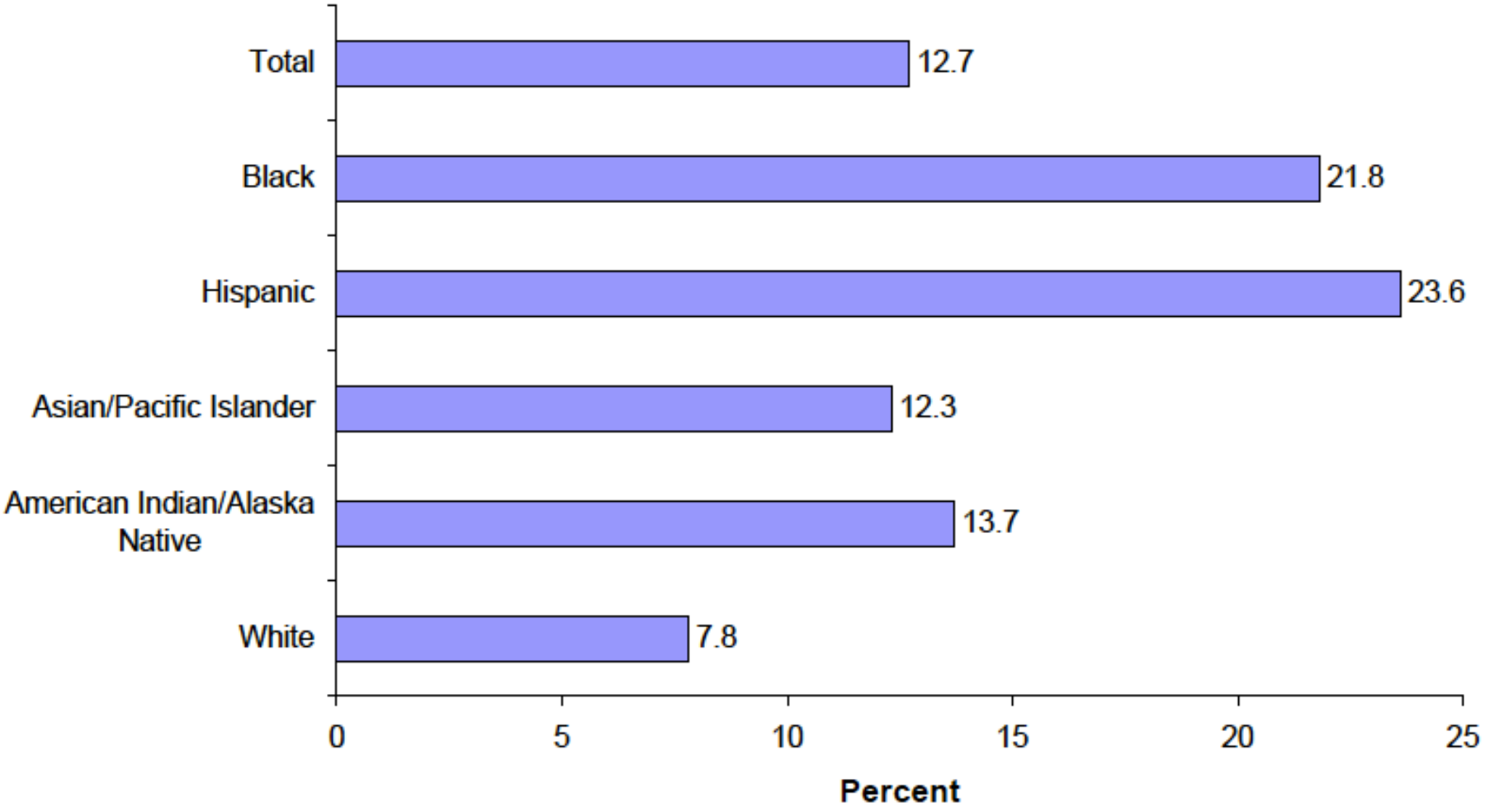


Figure 35. Infant Mortality Rate (IMR), Connecticut Residents, by Race or Ethnicity, 2001–2005

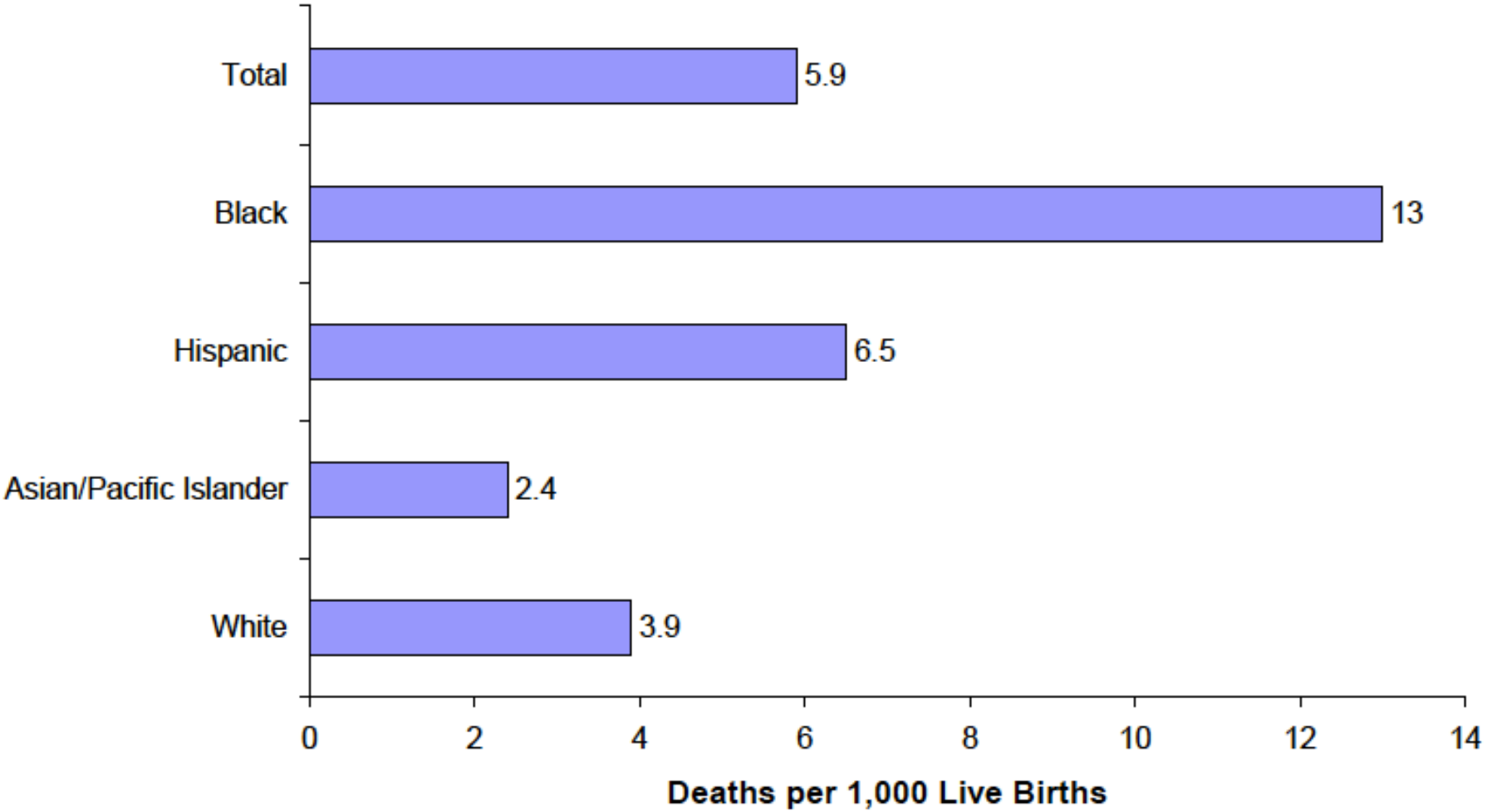


Table 33. Oral Health Status of Connecticut's Kindergarten and Third Grade Children, by Race or Ethnicity as a Percent of Each Racial or Ethnic Group, 2006–2007

Race[a] or Ethnicity	% with caries experience	% with untreated decay	% with rampant decay	% needing treatment
African American (n=938)	42.8*	25.0*	16.4*	19.8*
Hispanic (n=859)	49.3*	26.9*	19.5*	20.9*
Asian (n=173)	42.0*	18.8	18.1*	15.3
White (n=5,579)	28.9	13.0	7.9	9.1

Figure 41. Rates of Emergency Department (ED) Visits, Primary Diagnosis of Asthma, Connecticut Resident Children 0–17 Years of Age, by Race or Ethnicity, 2004

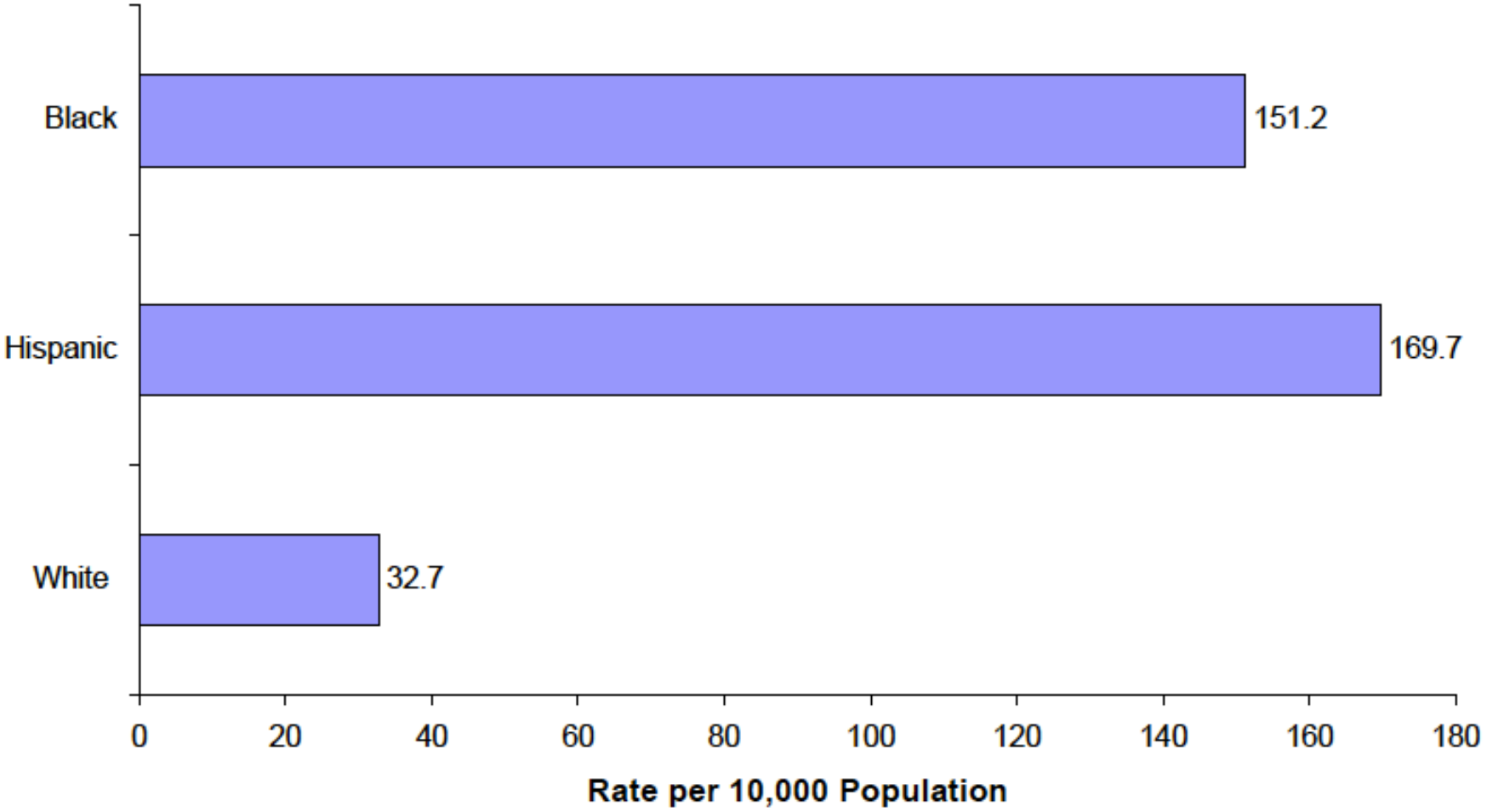


Figure 6. Diabetes Prevalence, Connecticut Residents, by Race or Ethnicity, 2004–2006

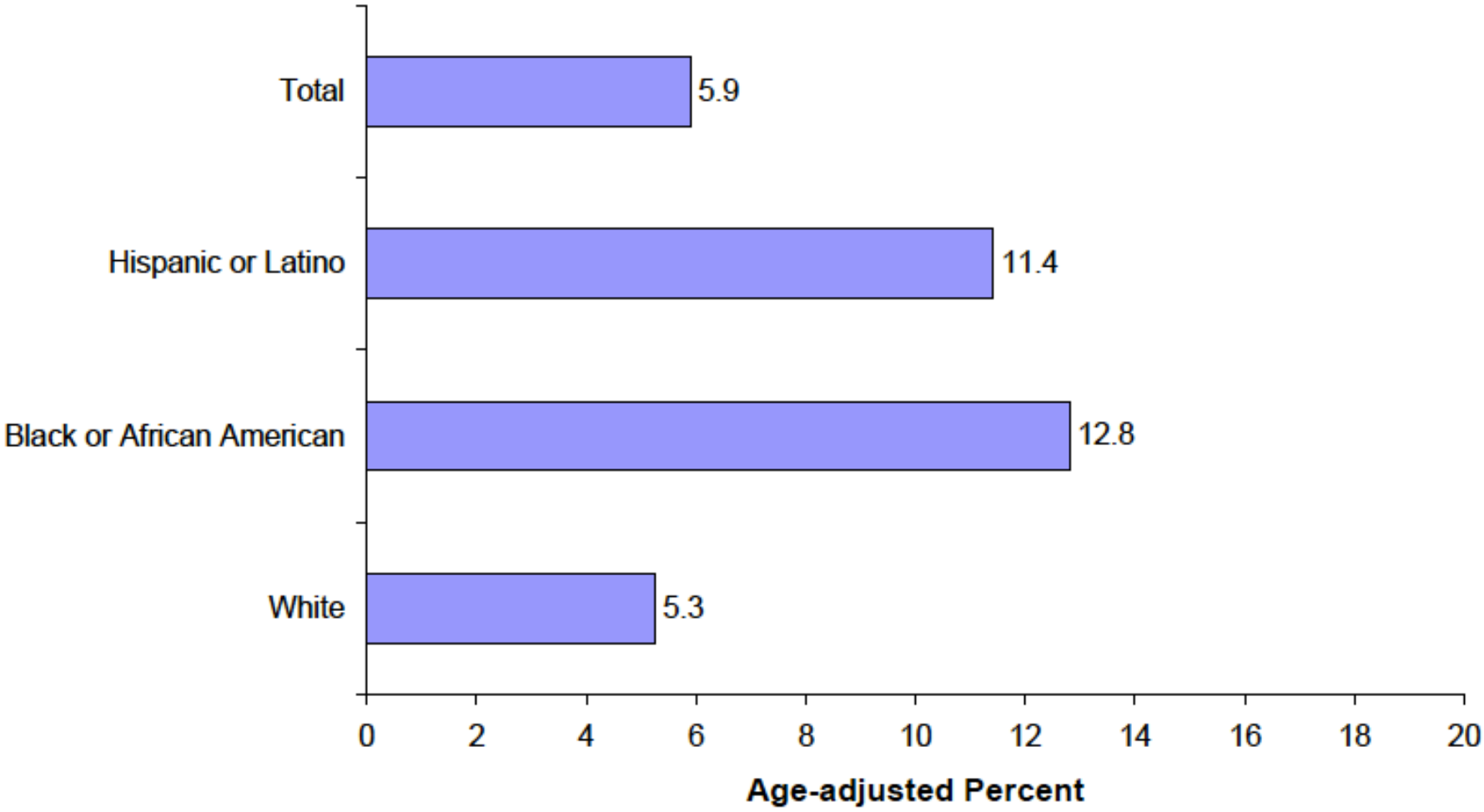


Figure 9. Age-adjusted Hospitalization Rates for Diabetes with Lower Extremity Amputation, Connecticut Residents, by Race or Ethnicity, 2005

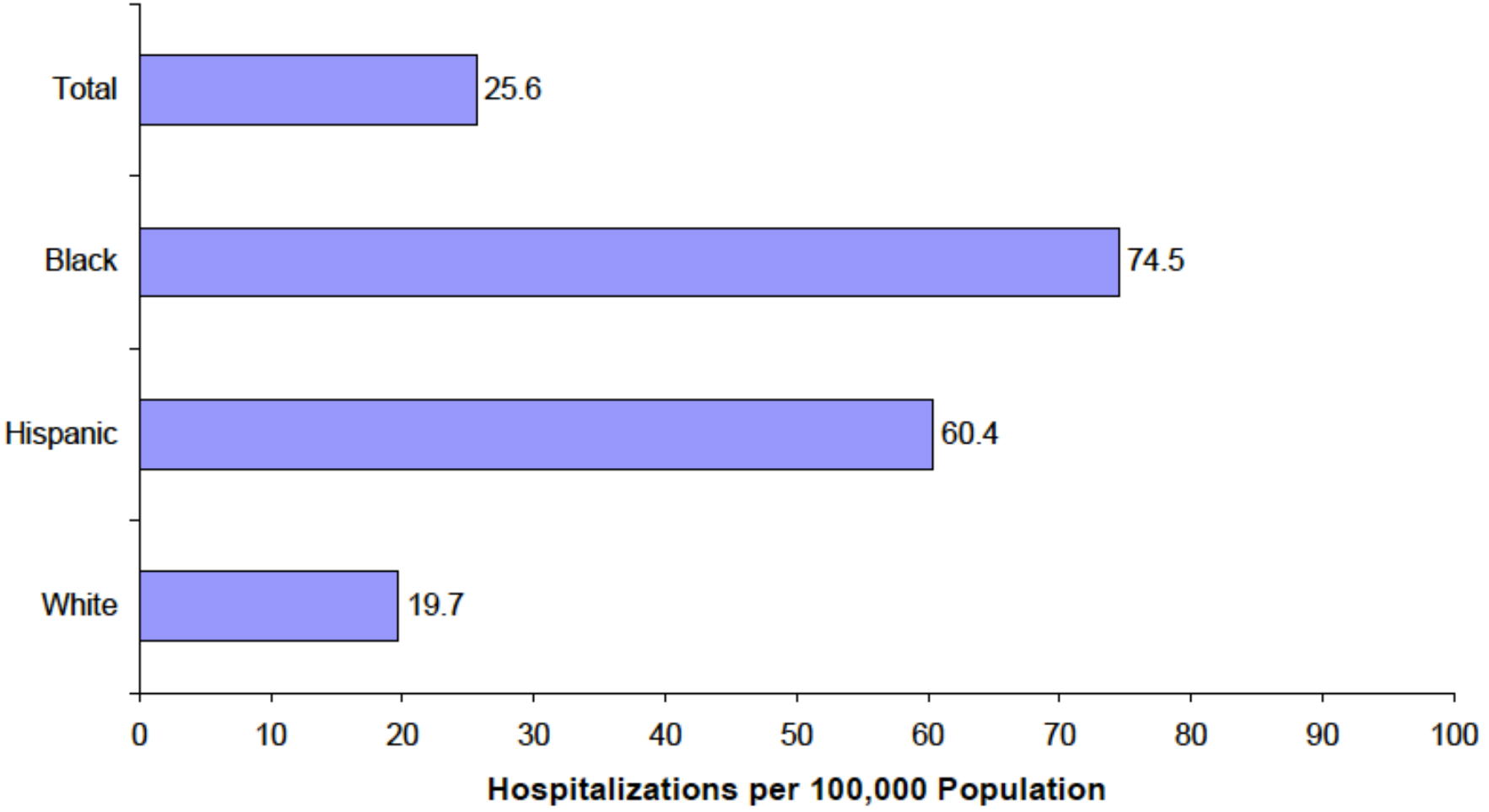
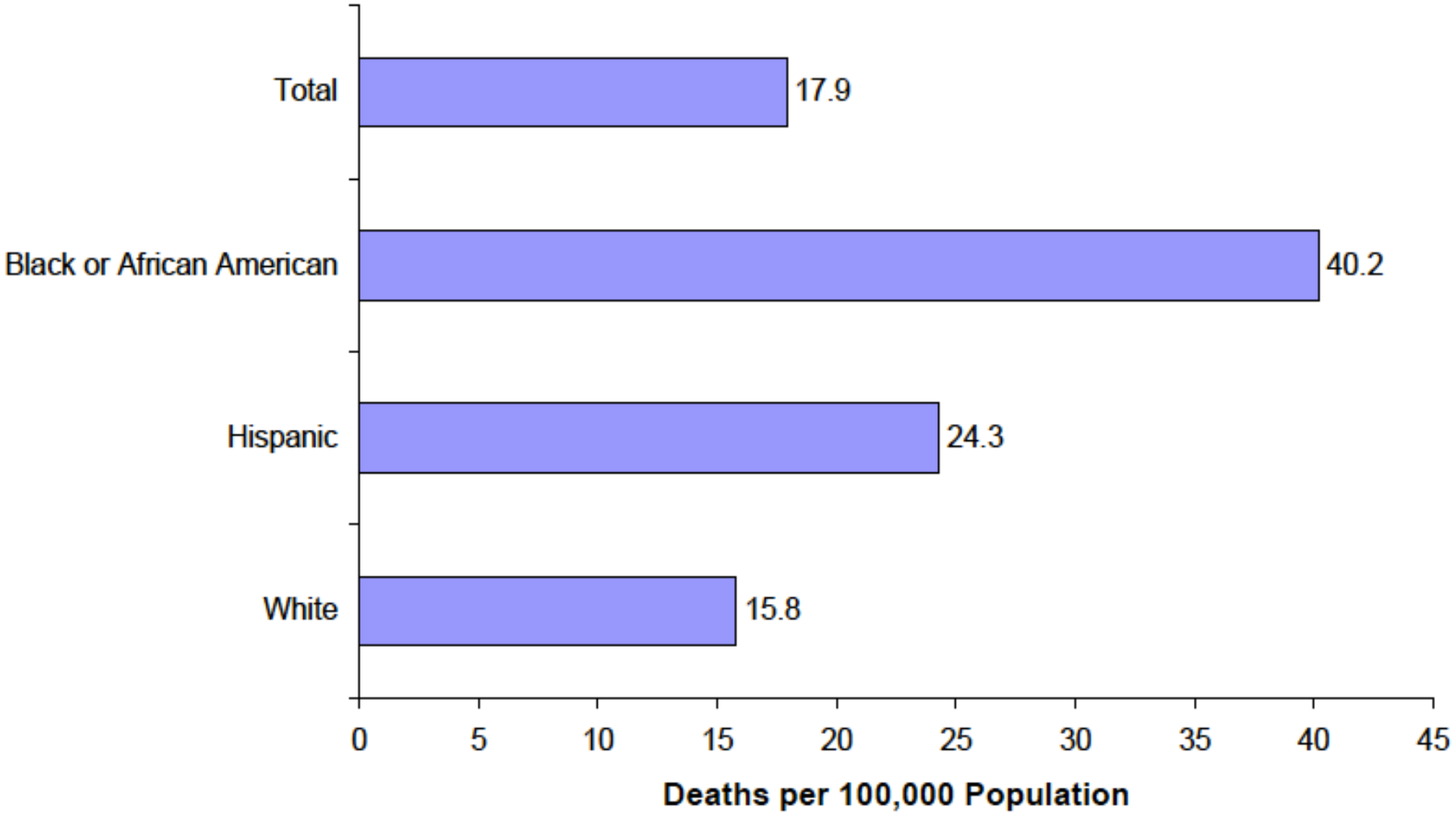
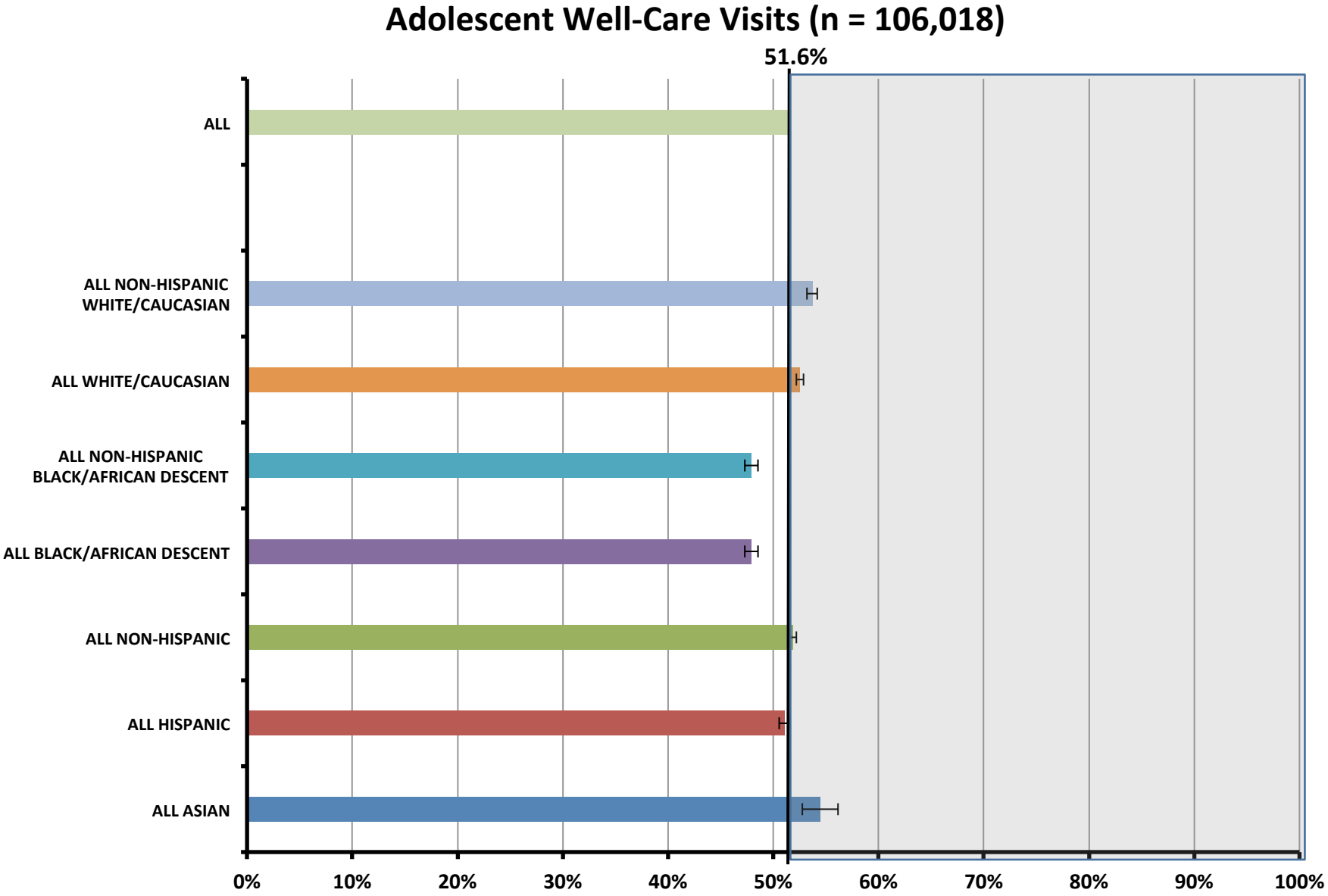
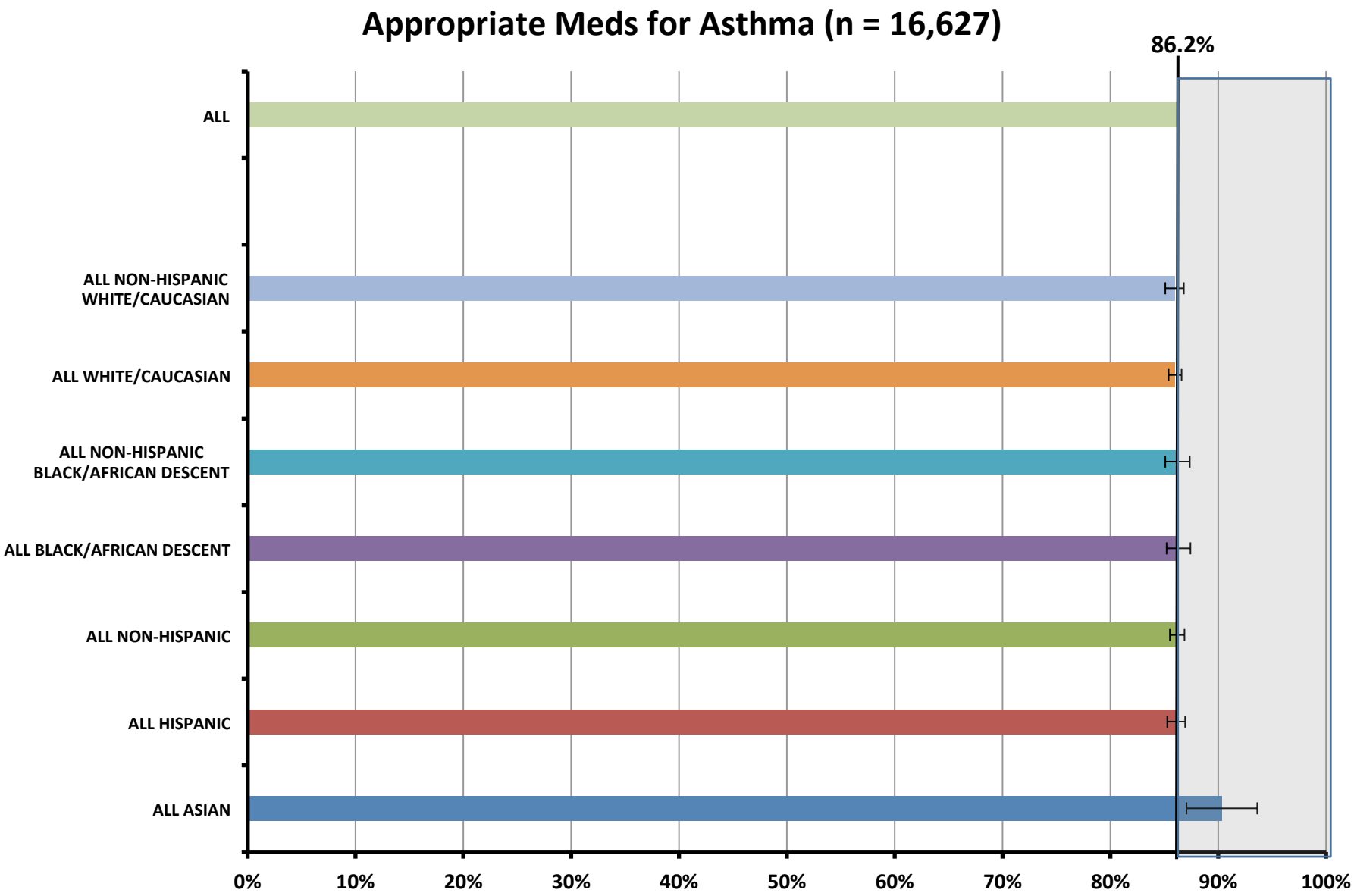


Figure 7. Age-adjusted Death Rates for Diabetes, Connecticut Residents, by Race or Ethnicity, 2000–2004

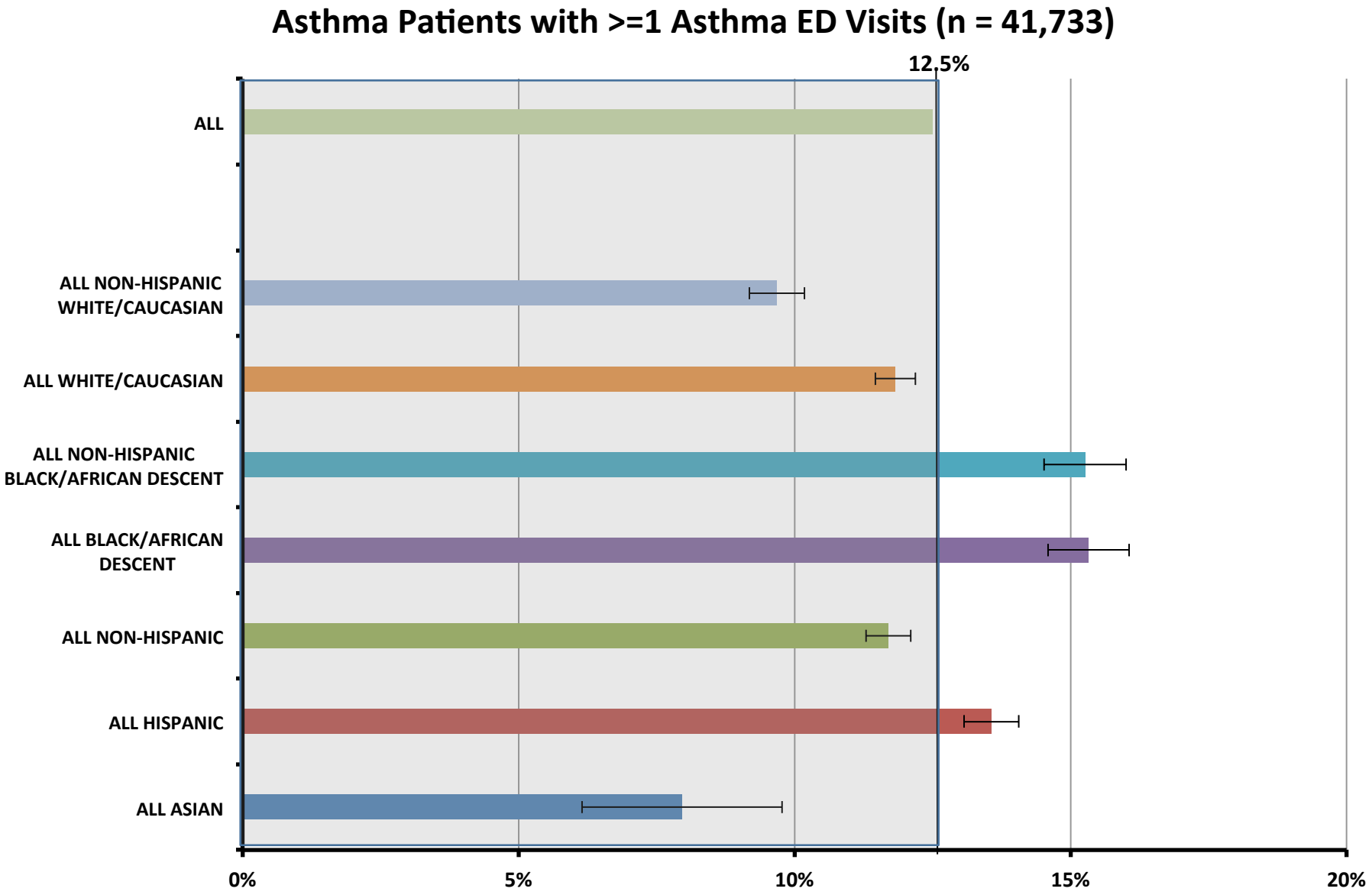




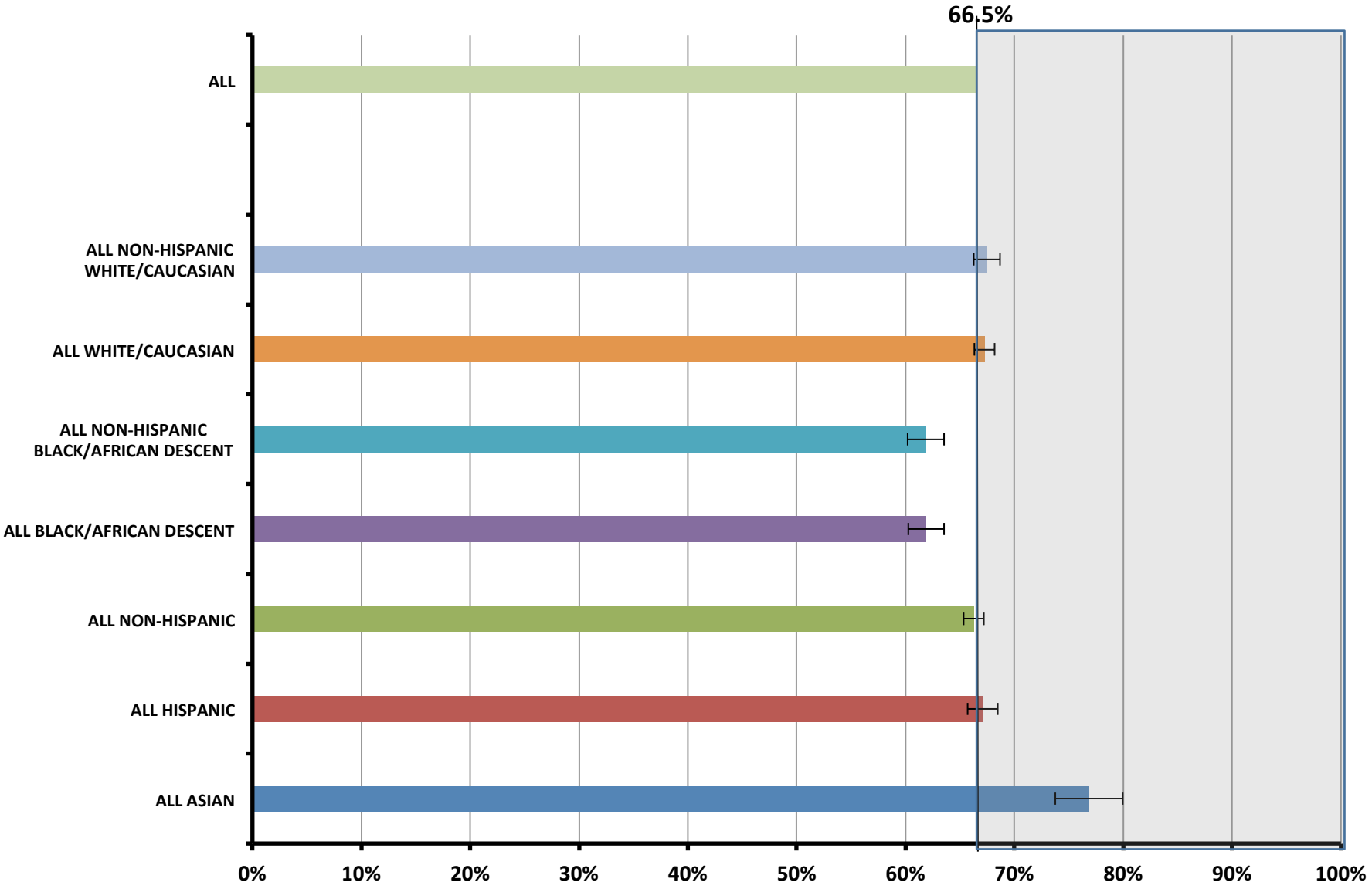
Percentage of CT Medicaid members (excluding dual eligible members) 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN during the 2012 measurement year.



The Percentage of CT Medicaid members (excluding dual eligible members) 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the 2012 measurement year.



Percentage of CT Medicaid members (excluding dual eligible members) 2-20 years of age diagnosed with asthma with one of more asthma-related emergency department (ED) visits during the 2012 measurement year.



Percentage of CT Medicaid members (excluding dual eligible members) 18-75 years of age diagnosed with diabetes who had an LDL-C test performed during the 2012 measurement year.

Assessment Tool Resource

- www.ctmhp.org; Connecticut's website for information on Multicultural Health
- To access assessment tool
- Click on Resources tab
- Under "Helpful Resources"
- Under "CLAS Organizational Assessment Tools"
- Click on link for CLAS Standards Assessment Tools from TMF-Health Quality Institute

Resources

- Office of Minority Health http://www.minorityhealth.hhs.gov/
- Think Cultural Health www.thinkculturalhealth.hhs.gov
- Healthy Roads Media www.healthroadsmedia.org
- Health Information Translations www.healthinfotranslations.org
- Hablamos Juntos www.hablamosjuntos.org
- AHRQ http://healthcare411.ahrq.gov/aprendeavivir.aspx
- ethnoMED www.ethnomed.org
- www.depts.washington.edu/pfes/CultureClues.htm

Resources

- Culture, Language and Health Literacy www.hrsa.gov/culturalcompetence/index.html
- CPEHN California Pan-Ethnic Health www.cpehn.org/clstudies.php
- National Center for Cultural Competence www11.georgetown.edu/research/gucchd/nccc
- CHSC Center for Health Care Strategies www.chcs.org
- Cultural Linguistic Access Services are at no cost to CHNCT Active Members 800-859-9889

ASO Resource Contacts

- Intensive Care Management
  Manager, Intensive Care Management
  (800) 859-9889, ext. 7274

- Specialized Intensive Care Management
  Manager, Specialized Intensive Care Management
  (800) 859-9889, ext. 6052

- Transitional Care
  Manager, Transitional Care
  (800) 859-9889, ext. 6047

ASO Resource Contacts (Cont.)

- Community Support Services
  Manager, Community Support Services
  (800) 859-9889, ext. 7276

- Community Practice Transformation
  Program Administrator
  (800) 859-9889, ext. 6133

- Regional Network Management
  Director, Network Management
  (800) 859-9889, ext. 4152

Questions?