



Data-Driven Approaches to Reduce Disparities

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Overview

- Introduction to CHCS
- Snapshot of the CHCS Disparities Portfolio
- How data is used to identify and monitor improvements in disparities
- What we've learned in our efforts to reduce disparities
- Question & Answer

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The Center for Health Care Strategies

Our Mission

- To improve health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

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Program Priority Areas

Our work with local, state and federal agencies; Medicaid and Medicare health plans; providers; and consumers focuses on:

- ➔ Advancing Health Care Quality and Cost-Effectiveness
- ➔ Reducing Racial and Ethnic Disparities
- ➔ Integrating Care for People with Complex and Special Needs

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CHCS and Children's Health

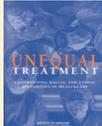
With support from the Annie E. Casey Foundation for its Children in Managed Care Program, CHCS is working with states and localities, managed care organizations, and family/consumer based organizations to improve the quality of care and outcomes for children with complex physical and behavioral health needs being served in publicly-financed systems.

- Children and Youth with SED
- Children involved in Child Welfare
- Medicaid-eligible children/EPSTD Services

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Key Facts on Racial and Ethnic Disparities in Health Care



- National
 - IOM Study
 - AHRQ National Healthcare Disparities Report
 - Ethnic minorities are less healthy than whites and have less access to health care
- Medicaid
 - Over half of beneficiaries under age 65 belong to a minority group
 - 60 percent of beneficiaries are in managed care
 - Managed care = a leverage point for improving quality

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Key Facts on Racial and Ethnic Disparities in Health Care



- Mental Health-Specific
 - 2001 Surgeon General's Report on Mental Health: Culture, Race and Ethnicity
 - President's New Freedom Commission on Mental Health
 - SAMHSA's Transformation Agenda
- Child Welfare
 - List seminal works

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CHCS Disparities Portfolio



- Disparities Best Clinical and Administrative Practices
- Disparities Purchasing Institute
- National Health Plan Collaborative
- Practice Size Exploratory Project
- Child Welfare Quality Improvement Collaborative
- Supporting Practice Improvement to Reduce Disparities

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Legal Issues in R/E Data Collection and Sharing



- Early Analysis
 - GWU Study: Title VI of 1964 Civil Rights Act does not prevent MCOs from legally collecting R/E data in support of QI efforts
 - R/E data collection to-date determined to be consistent with regulations and in compliance
- Pending Analysis
 - Determine legality of health plans using employer collected race/ethnicity data for patient level QI interventions (GWU)

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Addressing Disparities Starts with Data



- CHCS projects' use of race and ethnicity data is tightly proscribed:
 - Identifying disparities
 - Targeting interventions
 - Monitoring impact on reducing disparities
- No federal mandate in health care to collect data on race and ethnicity.
- State-level race/ethnicity data collection mandates vary.

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Types of Data Sources



- Direct
 - Based on self-report
 - Advantages
 - Most accurate
 - Available to MCOs through Medicaid and MMC eligibility and enrollment data
 - Useful for provider/patient level interventions
 - Limitations
 - Voluntary = Inconsistent
 - Examples: Survey, Vital Records, Census Data

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Types of Data Sources



- Indirect
 - Based on assumptions
 - Advantages
 - Used primarily by commercial plans without access to direct information through employers
 - Can be used for community level interventions or to identify potential target areas for intervention
 - Limitations
 - Less likely to be accurate
 - Mis-assignment can skew results and conclusions
 - Examples: Geo-coding, Surname Analysis, Observation

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**Uses of R/E Data in Medicaid:
 Disparities Health Plan Collaborative**



- 12 managed care organizations with 3.2 million Medicaid/SCHIP enrollees from across the country
- Initial Challenge: "How do we identify the members of racial and ethnic minority groups?"
- QI interventions addressed disparities in prenatal care/birth outcomes, asthma, diabetes, immunizations, and HEDIS rates

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**Highlighted Outcomes:
 Disparities BCAP**



- **Blue Cross of California State Sponsored Business:** Pharmacy consultation initiative for African American members with asthma improved consultation rates from 29% to 55%
- **Monroe Health Plan:** Peer outreach for pregnant African American teens reduced NICU admissions and achieved a positive ROI of \$2.86 for every dollar invested
- **UPMC for You:** Community-based high-risk prenatal care program for African American women increased first trimester visits from 14% to 39% and reduced low birth weight rates from 7.9% to 5.3 %

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**Uses of R/E Data in Commercial MCOs:
 National Health Plan Collaborative**



- Phase One (*completed*)
 - Identifying Viable Indirect Data
 - Focus on HEDIS Indicators by Race
 - QI in area of Diabetes
- Phase Two (*ongoing*)
 - Testing various direct and indirect approaches to determine advantages and limitations

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**Highlighted Findings:
 National Health Plan Collaborative**



- Engage employers to establish trust
- No one approach is sufficient
- Online data methods for younger, commercial members
- Language is a sensitive issue

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**Uses of R/E Data in Medicaid:
 The Practice Size Exploratory Project**



- Data analysis aimed at identifying "High volume/High opportunity" practices (AR, MI, NY, PA) to which Quality Improvement activities will be targeted
 - High Medicaid volume
 - High volume of racial/ethnic minorities
 - High chronic disease burden
 - Low performance on quality indicators
 - Contracts with low number of MCOs
- Solo practitioners - FQHCs

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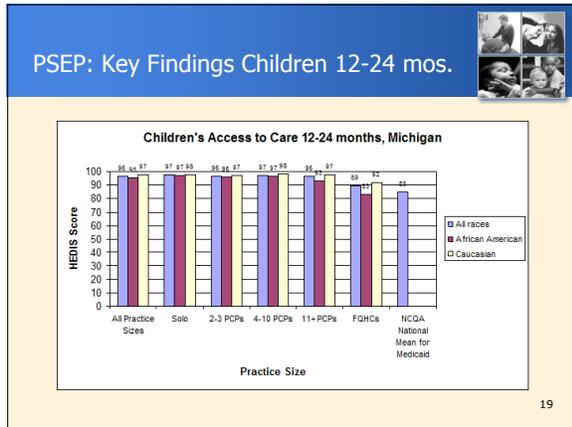
**Highlighted Findings: MICHIGAN MEDICAID
 The Practice Size Exploratory Project (PSEP)**



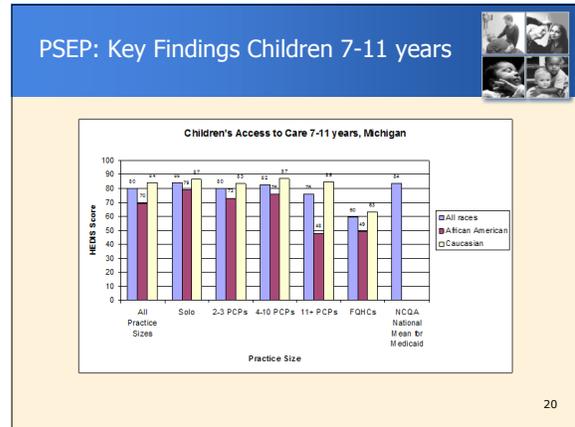
Demographics:

- 64% of members were children age 0-19
 - largest percentage (26%) being between age 25 months old and 6 years old
- 50% of members are racial/ethnic minority groups
 - 43% African American
 - 5% Hispanic
 - 2% Asian Pacific Islander or Native American

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Uses of R/E Data in Medicaid: A Focus on Child Welfare

CHCS has partnered with ten managed care organizations to improve physical and behavioral outcomes for children involved in child welfare.

Participating MCOs are working to:

- Increase access to care,
- Improve coordination of physical and behavioral health care,
- Implement medical/behavioral health homes, including the use of electronic medical records, and
- Identify best practices in behavioral health pharmacy management.

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Disparities among Children in Child Welfare

- Minority children are over-represented in Child Welfare
 - African Americans represent only 15% of the total population but their children comprise 40% of the foster care population. (*CWLA*)
 - Hispanic and African American children more likely to be placed in foster care even when analysis are controlled for race. (*Race Matters*)
 - Differential rates of reporting, investigations, and substantiation of claims for children of color. (*Family Violence Prevention Fund*)
 - No significant difference in rates of maltreatment when analyses are controlled for income. (*Family Violence Prevention Fund*)
 - *Greater vulnerability to adverse social, physical and behavioral health outcomes for children in foster care.*

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Uses of R/E Data in Medicaid: A Focus on Child Welfare

- Internal Data at the MCOs
 - Enrollment data for members of their plan
 - Profiles of providers within their network
 - Claims data for members receiving services and supports
- External Data
 - Health status-related...Medicaid agency
 - CW placement status...Child Welfare agency
 - Utilization data from other sectors of the state's managed care program (e.g. general, behavioral health/substance abuse, pharmacy)

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What Have We Learned?

- Addressing Disparities is Critical
 - There are clinical, policy, and business cases for reducing racial and ethnic disparities
- Data Collection
 - Data reliability varies
 - No single gold-standard
 - High-level aggregation is promising

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What Have We Learned?

- Standardization
 - More challenging as diversity increases
 - Government records inconsistent in the options that may be selected and vary across states/service areas
 - Communication across public systems – including child-serving systems – is lacking
 - Trust must be established regarding use of data through community, employers, public systems

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What Have We Learned?

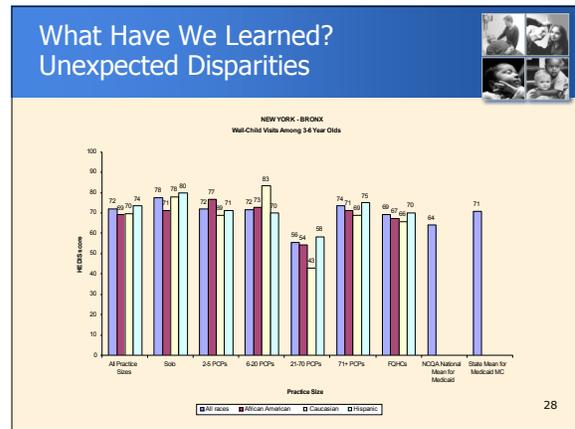
- Utility
 - Baseline information is critical to identifying areas of disparity
 - Race/ethnicity data are important to effectively targeting interventions
 - Multiple-level initiatives are more effective (system, provider, consumer)
 - Culturally competent approaches are critical

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- Utility
 - Baseline information is critical to identifying areas of disparity
 - Race/ethnicity data are important to effectively targeting interventions
 - Multiple-level initiatives are more effective (system, provider, consumer)
 - Culturally competent approaches are critical

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For Additional Information

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