

JOINT SENATE & ASSEMBLY HEALTH COMMITTEE
INFORMATIONAL & OVERSIGHT HEARING
Health Disparities in California
March 11, 2015 -- 1:30 p.m.
State Capitol, Room 4203

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Background

Communities of color are now and have been the majority of California's population, comprising 60% of the state's demographics. Before the passage of the Affordable Care Act (ACA), communities of color accounted for 75% of the uninsured and are projected to be the majority of the remaining uninsured despite all of the gains under the ACA. While the state has made tremendous strides in expanding health care coverage to low-income and communities of color, these communities have significantly higher rates of preventable chronic health conditions. Given the persistent health disparities experienced by communities of color, and the state's alignment with the "Triple Aim," it is imperative that payment and delivery system reforms prioritize health equity and primary prevention to ensure our goal of a healthy California is met.

As a nation, we have not made much progress in addressing the quality and access of health care for low-income and communities of color. According to the National Healthcare Quality and Disparities Reports, which focus on "prevailing disparities in health care delivery" related to racial and socioeconomic factors, there have not been significant changes in addressing disparities.ⁱ For example, nationally, Blacks and Latinos received worse care than Whites in 40% of quality measures, Asians received worse care than Whites for one-quarter of quality measures, and poor people received worse care than high-income people in 60% of quality measures.ⁱⁱ Additionally, Blacks (40%), Alaskan Native and American Indians (40%), Asians (25%), Latinos (60%), and poor people (in all but one measure) had worse access to care than Whites.ⁱⁱⁱ The report also notes the importance of collecting and analyzing data for small population subgroups, including Native Hawaiian or other Pacific Islanders. The report concludes by calling on for "our nation... to improve access to care, reduce disparities, and accelerate...quality improvement, especially in the areas of preventive care and chronic disease management."^{ivv}

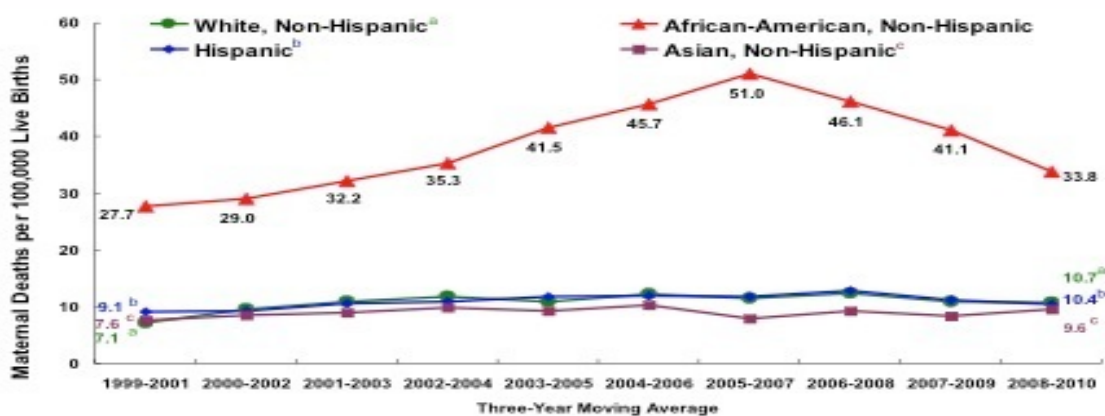
In California, communities of color face serious, life-threatening and debilitating yet preventable health conditions. These disparities span across communities of color and result in shorter life expectancy. They are also a result of social and environmental conditions that create inequities, including chronic stress from economic uncertainty, inability to afford healthy food, and increased exposure to environmental health risks. The lack of standardized data collection and analysis of health disparities fuels the state's inability to accurately identify the communities experiencing the greatest needs and work with health plans and providers to improve health outcomes. Below are some examples of health disparities:

- Diabetes related complications and preventable hospital admissions:** African Americans are 3.5 times and Latinos are 2.5 times more likely to experience preventable hospital admissions than Whites. These communities are more than twice as likely to undergo preventable amputations as compared to Whites.

Complications due to diabetes	African American	Latino	Asian/Pacific Islander	White
Preventable hospital admissions for diabetes with long-term complications (per 100,000 adults, 18 and over) ^{vi}	269.1	187.9	68.9	77.0
Preventable hospital admissions for diabetes with short-term complications (per 100,000 adults, 18 and over) ^{vii}	138.6	43.3	11.5	46.5
Preventable lower extremity amputations among patients with diabetes (per 100,000 adults, 18 and over)^{viii}	69.9	51.8	12.6	20.7
Preventable hospital admissions for diabetes with short-term complications (per 100,000 youths, age 6 through 17) ^{ix}	34.1	18.4	7.5	27.7

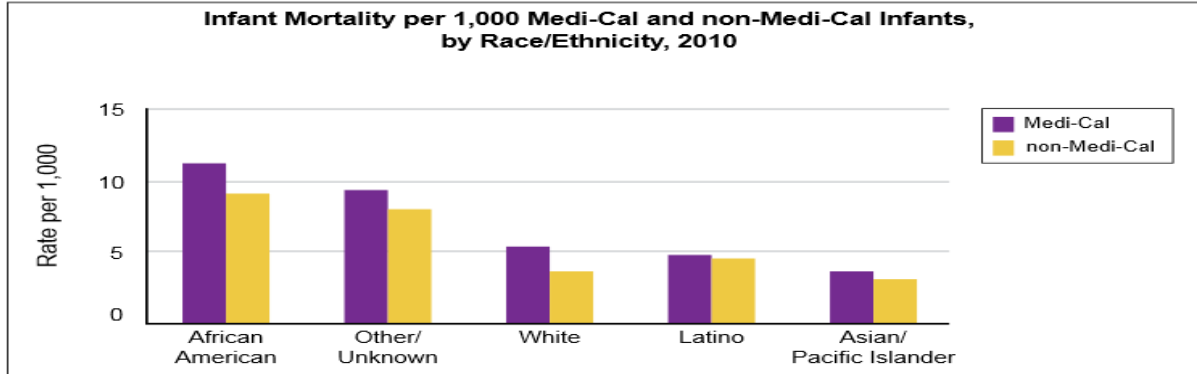
- Child and Maternal Health:** African American mothers are three times more likely to die from pregnancy-related causes. Disparities among African American and Latinas have been worsening as well. According to the California Maternal Quality Care Collaborative, “Maternal mortality for U.S.-born Hispanics increased by 47% from 1999-2001 to 2008-2010. This ... is a concerning development since over half of all births in California, or more than a quarter of a million births annually, are to Hispanic women.”^x


Maternal Mortality Rates by Race/Ethnicity, California Residents; 1999-2010

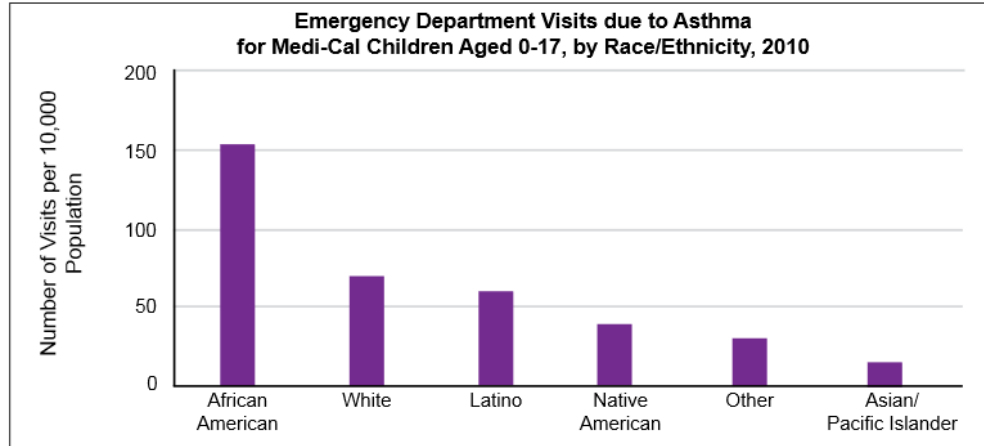
SOURCE: State of California, Department of Public Health, California Birth and Death Statistical Master Files, 1999-2010. Maternal mortality rates for California (deaths 5-42 days postpartum) were calculated using the ICD-10 codes for 1999 to 2010. Produced by California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Division, December, 2012.

- Infant Mortality:** In addition, infant mortality is higher overall for infants on Medi-Cal and among African Americans, infants are more than twice as likely to die as other infants according to data from the California Department of Public Health:



Source: Birth Cohort File, California Department of Public Health, 2010.
 Note: Rates for Native Americans were not shown due to small numbers. Rates for the groups "Other" and "Unknown" as well as "Asian" and "Pacific Islander" were combined to get more reliable rates.

- Asthma:** Asthma prevalence is highest among African Americans and rates of asthma-related emergency room visits are three times higher for African American children.



Source: Numerators: Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data, 2010; Denominators: Medi-Cal MIS/DSS, 2010.
 Note: Members eligible for both Medicare and Medicaid were excluded.

- **Hypertension:** According to data from AHRQ’s 2010 California Snapshot, African American adults’ preventable hospital admission rate for hypertension was five times that of Whites. Latinos are twice as likely as White to have preventable hospital admissions and preventable admissions for congestive heart failure.

Hypertension related conditions	African American	Latino	Asian/Pacific Islander	White
Preventable hospital admissions for hypertension (per 100,000 adults, 18 and over) ^{xi}	124.9	42.3	30.2	22.5
Preventable hospital admissions for angina without procedure (per 100,000 adults, 18 and over) ^{xii}	60.7	35.8	18.2	24.6
Preventable hospital admissions for congestive heart failure (per 100,000 adults, 18 and over) ^{xiii}	829.7	352.2	223.4	272.4

- **Behavioral Health:** Statewide communities of color reported higher rates of mental health and violence related needs. For example, students of color report having depression-related feelings at higher rates than White students, with Pacific Islanders having the highest rates. Further, women of color tend to experience higher rates of intimate partner violence during pregnancy.

Students Reporting Depression-Related Feelings Statewide^{xiv}

African American	28.8%
Latino	31.4%
Native American	31.6%
Asian	27.8%
Pacific Islander	34.0%
White	27.2%

Physical or Psychological Intimate Partner Violence During Pregnancy^{xv}

African American	15.2%
Latino	10.5%
Asian/Pacific Islander	9.4%
White	4.4%
Statewide Total	8.8%

The majority of Medi-Cal enrollees are from communities of color yet there are no requirements to analyze quality data by race, ethnicity, and primary language.

Today, 12 million lives or one-third of Californians are covered by Medi-Cal, 80% of whom are in Medi-Cal managed care. As of 2014, 7.8 million Californians were enrolled in Medi-Cal managed care, the majority from communities of color. Among these, 54% are Latino, 3% are Asian and Pacific Islander, and 9% are African American. In addition, 43% speak a language other than English.^{xvi} Recently CalSIM estimates project that 72% of the newly eligible for Medi-Cal are people of color, and 37% are Limited English Proficient (LEP).^{xvii} While health plans are required to report HEDIS measures and conduct quality improvement projects, which identify a few areas of improvement, there are no current requirements for Medi-Cal managed care plans or commercial plans in Covered California to report HEDIS measures or develop quality improvement projects that focus on reducing health disparities. Such projects could go far in helping to improve the health of communities of color and reverse some of these persistent trends in health disparities.

Disparities reduction strategies are important in a Post-ACA health care world.

The passage of the Affordable Care Act (ACA) did not only establish health care coverage for many of the previously uninsured. Provisions of the federal law also created a new focus on quality, cost, and population health including value-based purchasing, the Hospital Readmissions Reduction Program, and criteria for meaningful use of electronic health records. Additionally, the “Triple Aim: Better Care, Lower Cost, and Better Health” has become of the mantra of the Centers for Medicaid and Medicare and California’s Department of Health Care Services on payment and delivery reform. However, key health care leaders, including Dr. Robert Ross of The California Endowment, have advocated for a fourth aim – health equity – to ensure quality improvement measures do not result in negative consequences for low-income, communities of color, and safety-net providers.

In January, Secretary Burwell announced new goals and timelines for shifting Medicare reimbursements to alternative payment models such as Accountable Care Organizations or bundled payments.^{xviii} By 2016, 30% of Medicare fee-for-service payments will be tied to these alternative payment models, and 50% by 2018. Additionally, the Secretary has called for 85% of all traditional Medicare payments to be tied to quality and value payment models by 2016, and 90% by 2018.^{xix} Little data exists on the impact of these payment models in improving the quality of care for consumers. However, recent studies have shown that California’s safety-net hospitals are likely to be penalized by these types of payment reforms. A recent Health Affairs article states: “Taken together, these results indicate that safety-net hospitals provided better health outcomes than other hospitals at a similar cost level yet were more likely to be penalized under programs that are intended to improve and reward high performance.”^{xx}

During California’s recent 1115 waiver stakeholder process, the state began entertaining the use of value based payment reforms, including pay for performance initiatives. While data on the impact of pay-for-performance incentives is lacking, some researchers suggest that disparities could be furthered under such programs. For example, programs seeking to improve quality through self-management might not consider cultural or other barriers that communities of color face in accessing care including language differences and transportation limitations.^{xxi} In addition, researchers suggest that providers might be pressured to focus time and attention on

care that is measured, rather than taking the time to consider the entire needs of the patient, including language or cultural barriers that may impact the patient's outcomes.^{xxii} This suggests the need for quality improvement payment strategies to be designed with an explicit focus on reducing health disparities, which could also be a better strategy in achieving the four aims, better care, lower costs, better health and *health equity*.

Analysis of quality data by key demographics including race, ethnicity, and primary language is already occurring by state agencies, private researchers, and some health plans.

There are several ways in which California is currently utilizing race, ethnicity, and primary language data to improve the health of communities of color. California's Medi-Cal managed care program conducts an analysis of the language needs of the Medi-Cal enrollees in order to assist plans in identifying which languages documents should be translated. Covered California has stepped up the analysis of enrollment data by race, ethnicity, and language to determine how to target resources to improve enrollment outcomes. Additionally, in the former Healthy Families program, staff conducted an analysis of health plans' quality data, in aggregate, by race, ethnicity, and language preference and published the reports online. Private researchers have also conducted analyses of quality data by race, ethnicity, and primary language to identify disparities in care. For example, Dr. Andy Bindman conducted a study entitled, *Health Plan Auto-Assignment Incentives in Medi-Cal and Health Care Disparities for Children*, where he analyzed quality measures to race, ethnicity, and primary language using information that plans voluntarily submitted.

Finally, in an effort to better identify and address member needs, health plans in other states have analyzed utilization patterns by race, ethnicity, and language. Using the findings, plans developed outreach and education programs to improve the quality of care and health outcomes of their members. The following are examples of model practices:

- **Aetna Breast Health Disparity Initiative:** Aetna sought to decrease breast cancer death rates among African American and Hispanic women by increasing the number of yearly mammograms. Aetna analyzed race, ethnicity, and language data collected at enrollment and claims data to identify 34,000 African American and Latina members who had not had a necessary mammogram. The rate of mammograms following outreach to these women increased from 12% to 27%.^{xxiii}
- **Molina Healthcare of Michigan:** African American men have the shortest life expectancy of all males in Michigan. To improve the health of their African American male members, Molina reviewed their claims and found that only 7% had preventive exams. After conducting targeted outreach to African American male members, the rates of preventive exams increased in the areas of cholesterol from 15% to 49%; glucose from 10% to 34%; and colorectal cancer from 8.6% to 19.7%.^{xxiv}

Conclusion and Recommendations

To begin addressing health disparities, the state must commit to advancing health equity in its delivery and payment reforms. A first step in addressing health equity is the identification of health disparities through the collection and analysis of data by key demographics including race, ethnicity, primary language, gender, and sexual orientation. In addition, data must be analyzed at the granular level to ensure subpopulations are not overlooked and we must prioritize the collection of data based on gender identity and sexual orientation. The collection and analysis of this data will help to:

- Identify populations most at risk for certain health conditions and their consequences.
- Understand the underlying systemic and environmental factors that negatively impact the health of specific communities.
- Develop culturally and linguistically appropriate public health and health care interventions.
- Efficiently allocate resources to communities and populations that are at highest risk.
- Assess the impact of interventions on diverse communities and the overall population.
- Assess the ability of diverse communities to access services and receive quality care.
- Measure the degree of representation of diverse communities in the health professions.

The following are suggestions to ensure the data is effective and that consumers' privacy is protected:

- **Standardization:** Race, ethnicity, primary language, gender identity, and sexual orientation categories and data gathering methods should be standardized to ensure comparability and consistency of information.
- **Collection:** Policies and procedures for government agencies, plans and providers on the collection of these key demographic data are necessary. Data should be collected accurately and voluntarily.
- **Analysis:** Data should be continually analyzed and updated to identify disparities, determine their causes, and track progress in eliminating them.
- **Utilization:** Government agencies, plans and providers should use data to develop programs to increase access, improve quality, and diversify the health care workforce.
- **Community Considerations:** The procedures and protocols should be made public to create an environment in which individuals understand the value of key demographic data, are willing to provide this information, and are protected from inappropriate disclosure or discrimination based on the information they provide.

In addition to these steps, we will need to create a bridge between our health care system and efforts to improve the social determinants of health. Below are additional recommendations to further address the needs of communities of color:

- Ensure providers are providing culturally and linguistically appropriate care.
- Integrate assessments of social determinants that are consistent barriers to better health.
- Establish coordination efforts to link patients to resources to improve health.
- Coordinate with and create bridges with California Department of Public Health's Health in All Policies Task Force.
- Incorporate data collection and outcomes data with Let's Get Health California Task Force Indicators.

Endnotes

- ⁱ 2013 National Healthcare Quality and Disparities Reports. U.S. Department of Health and Human Services. Agency for Healthcare Research and Quality. Publication No. 14-005-1, Aug. 2014.
www.ahrq.gov/research/findings/nhqrdr/index.html.
- ⁱⁱ Ibid.
- ⁱⁱⁱ Ibid.
- ^{iv} Ibid.
- ^v Ibid.
- ^{vi} Available at: <http://cpehn.org/chart/diabetes-long-term-complications-california-adults-2010>
- ^{vii} Available at: <http://cpehn.org/chart/diabetes-short-term-complications-california-adults-2010>
- ^{viii} Available at: <http://cpehn.org/chart/diabetes-related-amputations-california-adults-2010>
- ^{ix} Available at: <http://cpehn.org/chart/diabetes-short-term-complications-california-youth-2010>
- ^x 8. Xu J, Kochanek KD, Murphy SL, Tejada-Vera B. Deaths: Final data for 2007. National vital statistics reports; Vol 58 no 19. Hyattsville, MD: National Center for Health Statistics. 2010.
- ^{xi} Available at: <http://cpehn.org/chart/hypertension-california-adults-2010>
- ^{xii} Available at: <http://cpehn.org/chart/angina-without-procedure-california-adults-2010-0>
- ^{xiii} Available at: <http://cpehn.org/chart/congestive-heart-failure-california-adults-2010>
- ^{xiv} Available at: (<http://cpehn.org/chart/depression-related-feelings-california-2008-2010>)
- ^{xv} California Department of Public Health:
(<http://www.cdph.ca.gov/data/surveys/MIHA/MIHASnapshots/SnapshotbyRace2012.pdf>)
- ^{xvi} http://www.dhcs.ca.gov/dataandstats/statistics/Documents/3_61_Population%20Distribution_Ethnicity.pdf
- ^{xvii} <http://healthpolicy.ucla.edu/publications/search/pages/detail.aspx?PubID=1283>
- ^{xviii} <http://www.hhs.gov/news/press/2015pres/01/20150126a.html>
- ^{xix} Ibid.
- ^{xx} Gilman, Matlin, E. Kathleen Adams, Jason M. Hockenberry, Ira B. Wilson, Arnold S. Milstein, and Edmund R. Becker. California Safety-Net Hospitals Likely To Be Penalized By ACA Value, Readmission, And Meaningful-Use Programs. Health Affairs, 33, No. 8: 1314-1322. Aug. 2014.
- ^{xxi} Casalino, Lawrence P., Arthur Elster, Andy Eisenberg, Evelyn Lewis, John Montgomery and Diana Ramos. “Will Pay-For-Performance And Quality Reporting Affect Health Care Disparities?” At the Intersection of Health, Health Care and Policy, Health Affairs, 26, no. 3 (2007): w405-w414. April 10, 2007.
- ^{xxii} Ibid.
- ^{xxiii} “Innovative Practices in Multicultural Health 2007.” National Committee on Quality Assurance. Accessed at: www.ncqa.org/Portals/0/HEDISQM/CLAS/CLAS_InnovativePrac07.pdf.
- ^{xxiv} Ibid.