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Population Health Institute
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Issue Brief

Wisconsin's Health Care Quality: Among the Best…and Among the Worst

by Donna Friedsam

- Wisconsin's performance for **quality of care** ranks very weak for Blacks (Non-Hispanic) and for Hispanics (all races), compared to care delivered to Whites (Non-Hispanic).
- **Racial and ethnic disparities** in quality of care persist -- racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities-- even when controlling for socioeconomic differences and other health care access-related factors – such as insurance status and income.
- Patient-level, provider-level, and system-level factors appear to contribute to racial and ethnic healthcare disparities.
- National organizations have developed a **roadmap** for organizations seeking to reduce racial and ethnic disparities in health care.
- Organizations and providers need to **integrate targeted disparities interventions** into routine quality improvement efforts.
- Wisconsin providers lag in collecting data and integrating disparities focus in quality improvement efforts.

Wisconsin recently ranked second highest in the nation in overall health care quality scores by the federal Agency for Healthcare Research and Quality.[1] (Minnesota ranked as the top-performing state, beating Wisconsin by one-tenth of a percent.) Wisconsin earned an overall rating of "strong" on a range from very weak to very strong, with hospitals, home care agencies and physician clinics showing the strongest performance.

However, AHRQ rates Wisconsin's performance for quality of care very weak for Blacks (Non-Hispanic) and for Hispanics (all races), compared to care delivered to Whites (Non-Hispanic).[2] That is, a significant portion of Wisconsin residents receives less equitable care here than they would in most other states. Why would this be? What is being done in Wisconsin and elsewhere to address this? What should be done?

Wisconsin performed worse than the U.S. on 22 of 27 measures of quality, showing a greater disparity in performance between non-Hispanic Blacks and for Hispanics relative to Whites. Measures are based on potentially preventable hospital admissions, inpatient mortality, and potentially avoidable complications. Source: (Graphic and Text): AHRQ, 2001, National Healthcare Disparities Report.

Other Data

Similar disparities in Wisconsin's health care quality have been documented previously. The Dartmouth Atlas, in assessing the differences between care of White and Black Medicare beneficiaries, reported that Wisconsin's Black Medicare beneficiaries with diabetes are four times more likely to have a leg amputated than are Wisconsin's White diabetic Medicare beneficiaries.[3] Wisconsin performs in the lowest quartile nationally for Black leg amputations among Blacks relative to the U.S. average. Minnesota, neighbor and peer state to Wisconsin, also shows a significant disparity between Black and White rates but substantially better performance than Wisconsin.

These outcomes may be affected by challenges experienced more frequently by Black Medicare recipients – poor insurance coverage, multiple co-morbidities, and difficulty attaining adherence to care recommendations.[4] But such challenges

facing Black patients would presumably be the same challenges regardless of the state where they are receiving care, so such challenges would not explain the difference in care outcomes among the states. These data suggest that Black Medicare patients in Wisconsin receive care that differs from care received by Blacks in other states, at least with regard to more frequent leg amputation.

Leg Amputations: Ratio to U.S. average per 1,000, 2003-2006

	Overall	White	Black	Ratio
Wisconsin	**1.16**	**0.90**	**3.82**	**4.24**
Minnesota	0.85	0.66	2.03	3.07

Source: Fisher, 2008

Socio-economic causes?

Racial and ethnic disparities in health care are closely linked to differences in income and access to insurance. These factors, however, do not explain the degree of disparities observed.[4] Indeed, racial and ethnic disparities in quality of care persist -- racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities-- even when controlling for socioeconomic differences and other health care access-related factors – such as insurance status and income. The Institute of Medicine (IOM) reports that such disparities remain "remarkably consistent across a range of illnesses and health care services."

Wisconsin's AHRQ ratings tell this same story. Wisconsin's quality of care ranks in the "average" range for individuals living in low-income communities compared to high-income communities. This "average" rank, while lower than Wisconsin's overall rank of "strong," still exceeds the "very weak" care rating for Blacks and Hispanics. This suggests that something other than lower-income status is driving the "very weak" performance observed for Black and Hispanic residents.

Other national data also demonstrate that, when contact with the health care system occurs, race and ethnicity influence a patient's chance of receiving specific procedures and treatments.[5] Blacks diagnosed with heart disease are 13% less likely to undergo coronary angioplasty and one-third less likely to undergo bypass surgery than are Whites. Among preschool children hospitalized with asthma, only 7% of Black and 2% of Hispanic children, compared with 21% of White children, are prescribed routine medications to prevent future asthma-related hospitalizations.

Equal Care, or Equitable Care?

Healthy People 2020, the U.S. public health framework, defines a health disparity as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. (Wisconsin's State Health Plan, Healthiest Wisconsin 2020, identifies disparities as a cross-cutting Focus Area. http://www.dhs.wisconsin.gov/hw2020/report2020.htm) Health disparities adversely affect groups of people who have *systematically experienced greater obstacles* to health based on…*characteristics historically linked to discrimination or exclusion*."[6](emphasis added)

This definition refers to differences in health status and/or needs that develop based on avoidable circumstances well outside of the health care arena, such as systematic discrimination, bias, poor environment or unequal opportunity.

Health care will differ from person to person, and across groups, based on individual needs. Minorities may more often present with compromised health. But differences in health needs do not explain all inequalities in health care services.[7] Equitable care will not vary in quality because of someone's race, gender, income or location. However, care may vary in practice, because quality care – right care at the right time—differs among individuals.

Patient-Provider Disconnect

The Institute of Medicine (2003) reviewed possible causes of racial and ethnic difference in the quality of health care that are not due to access-related factors or to clinical needs, preferences, and appropriateness of intervention.[4] A range of patient-level, provider-level, and system-level factors appear to contribute to racial and ethnic healthcare disparities.

Even when insurance status is equal, care may be poorly matched to minority patients' needs, particularly if some patients face barriers of language, geography, or cultural familiarity. This may be

Equitable care does not mean treating every patient exactly the same. Instead, equitable care ensures optimal outcomes for all patients regardless of their background or circumstances.
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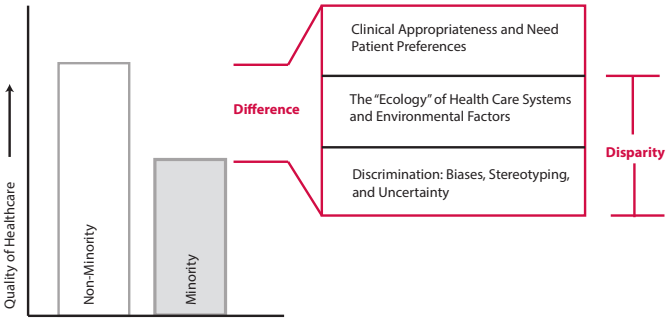
particularly acute in Wisconsin, where residential segregation for Blacks is rated the highest among all states in the country.[8]



Differences, Disparities, and Discrimination: Populations with Equal Access to Healthcare.

Source: Gomes and McGuire, 2001, Reprinted in IOM 2003.

Patient-Adherence and Predisposition

Providers, when faced with less-than-optimal performance data, often look to the risk and behavioral profile of their patients as an explanation: Patient preferences, treatment refusal, and care adherence can affect the clinical appropriateness and outcomes of care. Indeed, the IOM (2003) catalogues the studies showing minority patients slightly more likely to refuse recommended services. They may delay seeking care, and may be less likely to adhere to treatment regimens.

Disparities have also been attributed to biologically-based racial differences in clinical presentation or response to treatment. Such discussions weigh the legitimacy of inequalities: poor outcomes attributable to personal responsibility, lifestyle, risk-taking, preferences, choices, or genetic endowment might be considered "legitimate."[7]

Nonetheless, racial differences in care-seeking behaviors, preferences, attitudes, and biological factors do not explain observed disparities in care quality.[4]

> "Bias, stereotyping, prejudice, and clinical uncertainty on the part of healthcare providers may contribute to racial and ethnic disparities in healthcare."
> **Agency for Healthcare Research and Quality**

Patient behaviors and attitudes themselves may be shaped by quality improvement initiatives within health care delivery. Regardless of race or ethnicity, patient engagement and activation depend on a range of elements amenable to interventions in the practice climate[9] and other factors.[10,11]

The Care Process

Race/ethnicity has been shown to bias physician decision-making, affecting diagnosis and treatment, the likelihood of referral for specialist care, or a patient's receipt of advanced procedures.[5,2] The interplay of cultural and clinical uncertainty may further compromise provider effectiveness. Time pressures associated with the clinical encounter may further exacerbate any unconscious stereotypes that providers may hold.

Intervention Took-Kit

The Institute of Medicine, nearly a decade ago, called for reforming healthcare financing and delivery to promote overall quality, reduce costs, and address health disparities.[4] Recommended elements remain consistent with the overall trends in health care transformation:

- Care consistency and stability
- Usual sources of care
- Primary care focus
- Multidisciplinary and team-based care
- Evidence-based guidelines and care protocols
- Use of community health workers
- Patient education and engagement
- Linguistic and cultural competency
- Racial and ethnic diversity in the health professions
- Care management
- Reward for outcomes

Beyond these, the IOM noted the importance of equalizing access to high-quality health plans and coverage -- promoting access to the same health plans and providers for persons on public coverage as privately-insured patients.

More recently, the Finding Answers project, launched by the Robert Wood Johnson Foundation (RWJF), has developed a roadmap for organizations seeking to reduce racial and ethnic disparities in health care. It identifies best practices for implementing disparities interventions, synthesizing cross-cutting themes from 12 systematic reviews of the literature.

Finding Answers has identified steps for Reducing Racial and Ethnic Disparities in Care:

1. Recognize disparities and commit to reducing them.
   a. Stratify performance data by race, ethnicity and language.
   b. Conduct disparities training for providers and staff.
2. Implement a basic quality improvement structure and process.
3. Make equity an integral component of quality improvement efforts.

From here, steps 4) design, 5) implement, evaluate, and adjust, and 6) sustain the intervention(s).

Resources, Strategies, Best Practices

RWJF Finding Answers:
www.solvingdisparities.org

AHRQ Health Care Innovations Exchange:
www.innovations.ahrq.gov

AHA HRET Disparities Toolkit:
www.hretdisparities.org

American Hospital Association Tools: http://www.aha.org/advocacy-issues/disparities/casestudies.shtml

U.S. CDC Office of Minority Health & Health Equity:
www.cdc.gov/minorityhealth/OMHHE.html

National Academy for State Health Policy, State Policymakers' Guide for Advancing Health Equity:
http://nashp.org/sites/default/files/advancing.equity.health.reform.pdf

Data Collection and Measurement

The ability of hospitals, health plans, and other healthcare organizations to identify and address disparities hinges on effective collection of patient demographic data that captures race, ethnicity, language ("REL"), and income. Efforts are underway to solidify the infrastructure for REL data collection via patient self-report. Use of these data for disparities measurement support the same aims as overall quality measurement -- to monitor progress, stimulate improvement, and inform consumers and purchasers.[12]

The federal Patient Protection and Affordable Care Act of 2010, section 4302, requires the collection and reporting of quality performance measures stratified by race, ethnicity, and other demographic data.[13] The Institute of Medicine[14] recently recommended methods to collect such data, and groups such as the American Hospital Association's Health Research and Educational Trust have developed toolkits to guide organizations in this effort.[15] Providers, however, struggle to meet these intentions.[16] The American Hospital Association reports that, while 77% of hospitals responding to a survey affirm that they do collect REL data, only 18% use the data to benchmark gaps in care.[17]

REL proficiency, of course, goes well beyond use of data. The National Quality Forum has recently endorsed two measures to assess the effectiveness of language services in hospitals.[18] But even these measures are not sufficient. At least one study reports that cultural competency training and performance reports of the quality of diabetes care, stratified by race and ethnicity, increased providers' awareness of disparities, but did not improve clinical outcomes.[19]

A Quality Improvement Approach

Recent efforts go beyond documenting disparities, taking action to improve minority health within the healthcare setting.[20,21] Standard quality improvement efforts may improve outcomes across the aggregate patient population. But the quality differential between racial/ethnic groups may continue to grow.[22] In fact, attainment of overall quality goals may create a false sense of achievement and mask embedded inequities.

Quality improvement demands specific attention to the gap, assuring that such shortfalls remain visible. For this reason, the Institute of Medicine (2001) deemed equity a dimension that cuts across the other oft-cited dimensions – safe, effective, patient/family centered, timely, efficient care.

Analysis of disparities, in this model, occurs as an inextricable part of regular quality improvement. The same team of people focuses on integrated objectives. Interventions focus on overall system improvements and on specific populations and settings.

Promising interventions are being demonstrated in the health care sector. The Indian Health Service has focused on health information technology and telemedicine, comprehensive prevention and disease management programs, improving life-expectancy and measures of diabetes control.[24] An urban academic medical center in New York, seeking to improve outcomes for Hispanic patients, created

an integrated network of patient-centered medical homes linked to other providers and community-based resources. Six months of the program demonstrated a significant 9.2 percent decline in emergency department visits for ambulatory care–sensitive conditions.[25]

Hospitals often take leadership in such efforts. But the American Hospital Association 2012 Benchmark Study shows hospitals' significant lag in the collection and use of data and in cultural competency training. The report also suggests that hospitals might promote equitable care by advancing leadership diversity among their boards and staff.[17]

What's the Business Case?

A broad literature addresses the direct medical costs along with indirect costs -- such as lost productivity and social service burden -- associated with disparities. Wisconsin clearly has a stake in a healthy, self-sufficient workforce, particularly as the state population diversifies and must compete in an increasingly competitive global economy.

But what about the interests of individual provider entities, payers, and businesses? Current health care business trends offer opportunity and caution.

Current delivery reforms, through patient-centered medical homes and accountable care organizations, rely on team-based care -- a model that Finding Answers cites as consistently successful for disparities interventions. The states of Minnesota and Ohio have specifically linked their publicly-supported medical homes initiatives to a focus on health equity and care for racial and ethnic minority populations.[26]

> "Organizations and providers need to take responsibility for reducing disparities, establish a general infrastructure and culture to improve quality, and integrate targeted disparities interventions into quality improvement efforts."
> **Finding Answers www.solvingdisparities.org**

Payment reforms – bundled payments, pay-for-performance, and others -- focus on moving health care away from paying for volume to paying for quality. This elevates measurement and transparency, and links provider payment to their scores on various process and outcome measures. Risk-adjustments, however, are needed to support those providers (often already poorly resourced) that predominantly care for vulnerable populations, and to avoid patient dropping or providers' cherry picking of patients.[22,27] Alternative incentive models might incorporate safeguards such as pay-for-improvement, thereby encouraging participation by providers currently serving challenged populations and helping strengthen their position.

Wisconsin Going Forward

Wisconsin is home to several strong and nationally recognized health care quality efforts.[28] The state's health care providers receive national attention for pioneering quality efforts.[29] The Wisconsin Collaborative for Healthcare Quality and the Wisconsin Hospital Association lead in the arenas of quality measurement and reporting and have advanced a combined statewide effort as a national grantee under the RWJF Aligning Forces for Quality (AF4Q) Initiative.[30] MetaStar, Wisconsin's Quality Improvement Organization, works with providers to meet Medicare and Medicaid standards.

The Wisconsin Hospital Association has previously conducted trainings to promote the collection of REL data, share best practices, and assure the validity of the data. More than 50 health care organizations have participated in the trainings, although actual data collection and use still lags. Common barriers include a reluctance of staff to ask patients for the information, confusion about race and ethnicity categories, and a reluctance of patients to provide the information.[31] Through the national AF4Q, providers have access to technical assistance and consultation with the Finding Answers program.

Wisconsin's quality efforts, however, do not yet integrate disparities as a priority focus and have not reported specific progress. In this regard, and as borne out in the AHRQ performance report, Wisconsin's quality efforts lag.

The state boasts a highly-developed infrastructure and expert capacity to advance health care quality. Providers have continually raised the ceiling for performance expectations. The challenge remains, however, in showing leadership that assures equitable, optimal care across all races and ethnicities.

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University of Wisconsin
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AND PUBLIC HEALTH

Issue Brief

November 2012, Vol. 11, No. 2

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