The Medicaid MCO Experience in Addressing Health Equity

October 22, 2019 | 2-3 pm EDT
About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University’s Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

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Welcome from State Health and Value Strategies (SHVS)

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Today’s Facilitator and Presenter

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Housekeeping Details

All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at [www.shvs.org](http://www.shvs.org).
Agenda

1. Health equity webinar series
2. The HealthPartners experience in addressing health equity
3. Conversation and your questions
4. Wrap-up
Webinar Series Overview

• This series of five webinars was designed to assist state Medicaid agencies seeking to address health equity in partnership with their contracted Medicaid managed care organizations.

• Today’s webinar is the last in this series. Recordings and slide decks from previous webinars are available on www.shvs.org
Overview

• How we’ve created momentum
• What we’ve done
  – Framework for our work
  – Data collection
  – Actions taken
• Takeaways
Health Partners®

Health Plan
- 1.8 million health and dental members

Care Group
- 1.2 million patients
- 1,800 physicians
  - Park Nicollet
  - HealthPartners Medical Group
  - Stillwater Medical Group
- 55+ medical and surgical specialties
- 50+ primary care 22 urgent care locations
- 70 dentists
- TRIA Orthopedic Center
- Physicians Neck & Back Center
- virtuwell.com

Eight Hospitals
- Regions: 454-bed level 1 trauma and tertiary center
- Methodist: 426-bed acute care hospital
- Lakeview: 97-bed acute care hospital
- Hutchinson Health: 66 bed acute care hospital
- Amery, Hudson, and Westfields: Western WI hospitals
- St. Francis: 86-bed community hospital (partial owner)

HealthPartners Institute
- 400+ research studies each year; 550+ medical residents and fellows
Mission

To improve health and well-being in partnership with our members, patients and community

Vision

Health as it could be, affordability as it must be, through relationships built on trust

Values

Excellence | Compassion | Partnership | Integrity
Partners for Better Health Goals 2020

Health as it could be,

Care and coverage are:
- Compassionate
- Safe
- Coordinated
- Equitable

- Based on individual needs, well-informed decisions and what works
- Best-performing in quality for all
- Integrated to link good oral, mental and physical health

Members and patients have support, education and engagement for healthy lifestyles.
Community partnerships support social, economic and environmental health and well-being.

Annual Plan 2020

“Measurably improve health equity by addressing racial and economic disparities, and influence and participate in community collective action”

“Increase diversity across all roles and strengthen culture of inclusion across all teams”
Why?

Right thing to do

Business case
Business Case on Many Levels

- Return on investment to society
- Better care/outcomes lead to lower cost of care
- Improving overall quality results
- Attracting patients in changing demographic
Minnesota Trends

Source: State Demographic Center at Minnesota Planning

Communities of color in MN will grow faster than white population between 1995 and 2025

Percentage of people of color in MN:
19% (2015) → 25% (2035)
Our Approach to Health Equity

- Collect data and eliminate gaps in care
- Build understanding of equity, diversity, inclusion & bias
- Support language access
- Partner with communities

- Race/Ethnicity
- Language
- Income
- Sexual orientation
- Gender
- Age
- Physical ability
- Religion
Data Collection

• **2003:** Began measuring economic disparity gaps
• **2005:** Began asking patients to share their race, country of origin, and language preferred for care (now have for over 90% of patients)

• **Identify gaps:**
  – Typically didn’t see gaps in process measures
  – Largest gaps exist where additional visits or additional preparation required
  – Beliefs and perceptions about preventive medicine may also be at play
Data Collection – 2003
Payer Type

- % met commercial:
  - 2003: 2%
  - 2019: 48%

- % met Medicaid:
  - 2003: 0.05%
  - 2019: 38%
Data Collection – 2006
Race and Payer Type

Equitable: Optimal Diabetes by Payor and by Race/Ethnicity
(does not include North Suburban)

% met white
2006 – 16%
2019 – 51%

% met of color
2006 – 11%
2019 – 45%
Eliminate Disparities

While improving care for all...
Mental Health Length of Stay

Average Length of Stay by Language – Regions Hospital Mental Health

- **English**
  - Prior to simultaneous availability
  - Average LEP LOS 17.5 days

- **Limited English Proficient**
  - Since simultaneous available
  - Average LEP LOS 13.5 days

Inpatient Days

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<tr>
<th>Year</th>
<th>English</th>
<th>Limited English Proficient</th>
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<tbody>
<tr>
<td>2016 Q1-4</td>
<td>9.9</td>
<td>19.1</td>
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<tr>
<td>2017 Q1</td>
<td>9.7</td>
<td>15.9</td>
</tr>
<tr>
<td>2017 Q2-4</td>
<td>9.9</td>
<td>14.8</td>
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<tr>
<td>2018 Q1-3</td>
<td>10.4</td>
<td>12.1</td>
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Anti-Depressant Monitoring

- Refill reminders
- Targeted outreach (calls and letters)
- Culturally tailored training for clinicians and staff

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<tr>
<th>Anti-Depressant Medication Monitoring: Continuation Rates by Race</th>
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<tr>
<td>2015 HEDIS</td>
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<tr>
<td>------------</td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Of color</td>
</tr>
<tr>
<td>Medicaid Total</td>
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<tr>
<td>Disparity</td>
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Breast Cancer Screening by Race

Gap is 12.9% points
Gap is 7.7% points

HEDIS 2018 National 90th Percentile = 78.9%

Interventions

Same day access

Customized messages based on consumer insights data

Community outreach

Patients who are white Patients of color

1st Qtr 2006 2nd Qtr 2019

82.2% 69.3% 82.6% 74.9%

514
Colorectal Cancer Screening by Race

Interventions

- Decision supports in the electronic record
- Shared decision making (FIT/colonoscopy)
- Addressing clinician unconscious bias (FIT/colonoscopy)
- Patient outreach

*Black and Native American patients start screening at age 45, age 50 for all other races
Addressing Unconscious Bias

“Gold standard” language

Equitable Care Champions

• Grassroots program of champions to support education, awareness at local level.

• Over 170 Champions across the organization since 2003, expansion in 2016.

Colorectal Cancer Screening: Challenging Our Biases Around Screenings

The scenario

Each year, Allen, a 55-year-old African American, goes to the clinic for a preventive exam and labs required to refill his cholesterol-lowering medications. At each of these visits, his primary care clinician reviews his medical history and reminds him that he is due for a colonoscopy to screen for colorectal cancer. Allen has never had a colonoscopy. He works two jobs, has three kids, and has limited paid time off. This time, when the clinician tells him that it takes a few days to prepare for the procedure, Allen asks if there is another test he could have to see if he might have colorectal cancer. The clinician briefly describes the fecal immunochemistry test, or FIT, which Allen can take home as a kit, but his clinician quickly turns the conversation back to the colonoscopy. “The colonoscopy is just better because if polyps are found, we can remove them right then. Colonoscopy is what we call the ‘gold standard.’ That means it’s really the best choice, so that’s the screening I recommend.” Allen listens to the doctor intently. In his mind, he feels the FIT test would be a better option for him, but he doesn’t want to argue. “I guess I need to try to make this work,” Allen thinks. He sets up the colonoscopy for the following month.

HealthPartners®
Conversations about Race & Racism

2,000+ leaders engaged and charged to facilitate conversations with teams
## Community Partnerships

<table>
<thead>
<tr>
<th>Healthy Children</th>
<th>![Little Moments Count Logo]</th>
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<tr>
<td>Healthy Eating</td>
<td>![Power Up Logo]</td>
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<tr>
<td>Mental Health</td>
<td>![Make It OK Logo]</td>
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Health Partners

[Health Partners Logo]
Emerging Areas of Work

Maternal & Infant Health

LGBTQ Health

Screening and Referring for Social Determinants of Health
Takeaways

• Emphasize importance of health equity
• Integrate health equity into overall strategic and annual plans
• Involve Board and senior leaders in the work
• Collect data and regularly and transparently share results
• Focus on clinical improvements and culture
• Engage with patients and the community
• Do something! Don’t wait for perfection
Discussion

The slides and a recording of the webinar will be available at www.shvs.org after the webinar
Discussion

• Michael Bailit will pose several questions to panelist.

• We will then open up the discussion for your questions entered in the webinar Q&A box.

• The slides and a recording of the webinar will be available at www.shvs.org after the webinar.
Prior Webinars in the Series

1. **June 20**: Advancing Health Equity Through Medicaid Managed Care: An Introduction for States
2. **July 9**: Health Equity and Medicaid Managed Care: Data Collection and Measurement
3. **August 27**: Evidence-based Strategies for Reducing Health Disparities
4. **September 24**: Health Equity and Medicaid Managed Care: Using MCO Contract Performance and Requirements

Slides from prior webinars available at www.shvs.org
Thank You

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