MN Community MEASUREMENT

Leveraging Data to Better Understand and Address Disparities in Diabetes and Vascular Care

Community Webinar
May 23, 2022

Project supported by the Preparedness and Treatment Equity Coalition (PTEC)

WELCOME!

Thanks for joining us today.

All webinar participants are in “listen-only” mode. To ask a question, please type your question into the “Q&A” box at the bottom of your screen at any time during the webinar.

During the discussion section, you may also use the "raise hand" function to ask a question.

MNCM will send a link to presentation slides and the recording to webinar attendees later this week.

MNCM empowers health care decision makers with meaningful data to drive improvement.

What we do

Multi-stakeholder convening

Measure developer

Data collection, validation

Public transparency

How MNCM data are used

Quality improvement

Benchmarking

Value-based payment

Reducing disparities

Research partnerships

TODAY'S PRESENTATION

Project Background – *Julie Sonier*

Data Analysis & Key Findings – *Jess Donovan & Trisha Brinkhaus*

Strategies for Medicaid and Other Stakeholders – *Dr. Nathan Chomilo*

Audience Q&A

COLLABORATING PARTNERS & RESEARCH TEAM

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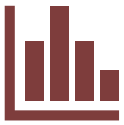
PROJECT GOALS

For patients who are Asian, Black, Indigenous/Native, and Hispanic/Latinx:

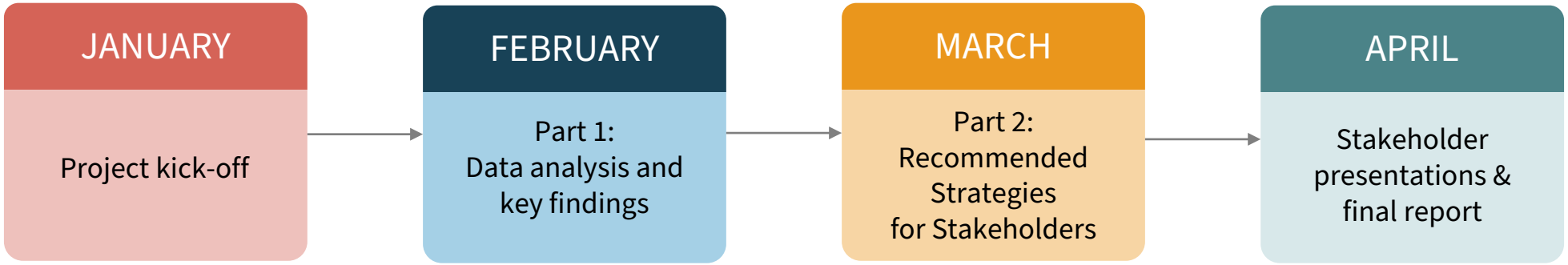
Understand the drivers of disparities in optimal diabetes and vascular care



Determine the best way to present actionable data to inform strategies to reduce disparities

Identify data-driven strategies to help target the root causes of disparities

PROJECT ROADMAP & TIMELINE



DATA ANALYSIS APPROACH

Three years of data – focused on care delivered in 2018-2020

2020: 281,000 for ODC and 156,000 for OVC

Data collected and validated from medical groups in Minnesota

2020: 88 reporting for ODC and 86 reporting for OVC

Includes high quality data on race, ethnicity, language, country of origin

2020: 97% best practice and >90% completeness in both measures

ABOUT THE MEASURES

OPTIMAL DIABETES CARE

The percentage of patients 18-75 years of age who had a diagnosis of type 1 or type 2 diabetes and whose diabetes was optimally managed during the measurement period as defined by achieving all of the following:

HbA1c < 8.0 mg/dL

BP < 140/90

Tobacco-free

On statin medication
(unless allowed contraindication)

If ischemic vascular disease, on daily aspirin or antiplatelet
(unless allowed contraindication)

OPTIMAL VASCULAR CARE

The percentage of patients 18-75 years of age who had a diagnosis of ischemic vascular disease (IVD) and whose IVD was optimally managed during the measurement period as defined by achieving all of the following:

BP < 140/90

Tobacco-free

On statin medication
(unless allowed contraindication)

On daily aspirin or antiplatelet
(unless allowed contraindication)

COMPONENTS OF ANALYSES

1. Statewide analysis
2. Race/Ethnicity
3. Insurance product
4. Geography

INTERSECTIONAL FACTORS

- Age
- Geography
- Race
- Ethnicity
- Language
- Country of Origin
- Insurance Type
- Social Vulnerability

STATEWIDE ANALYSIS

Results by Race/Ethnicity

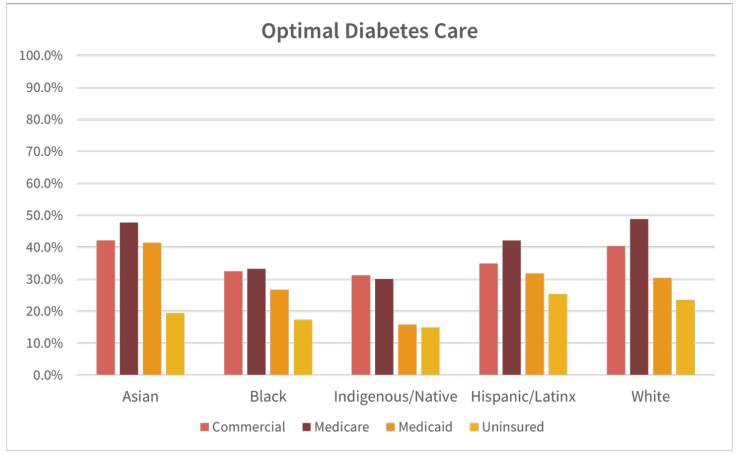
Example: Optimal Diabetes Care

RACE/ETHNICITY	NUMBER OF PATIENTS			COMPOSITE RATE		
	2018	2019	2020	2018	2019	2020
Asian	11,638	12,560	13,010	47.6%	48.6%	42.4%
Black	21,970	23,162	24,294	33.7%	35.0%	29.6%
Indigenous/ Native	3,783	3,846	4,087	25.0%	26.7%	23.3%
Hispanic/Latinx	11,692	12,067	12,944	36.5%	37.7%	33.2%
White	214,629	215,888	220,688	46.6%	47.0%	42.3%
STATEWIDE	**271,491**	**278,033**	**280,915**	**44.9%**	**45.4%**	**40.5%**

EXPANDING ANALYSIS

Example: Optimal Diabetes Care

BY INSURANCE PRODUCT



STATEWIDE RATES

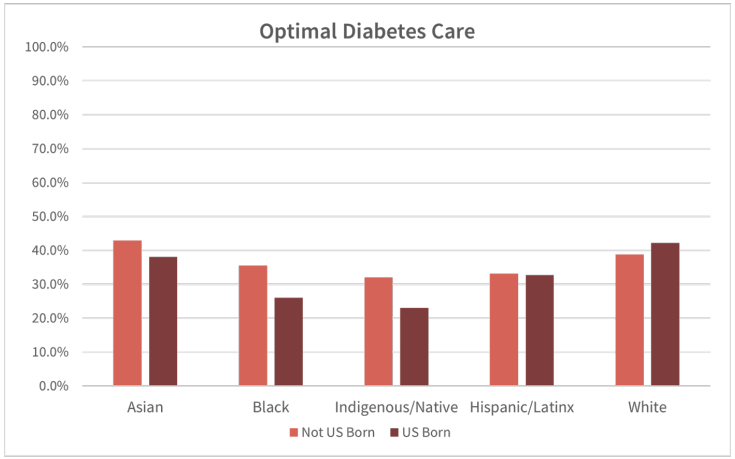
39.7% Commercial

47.7% Medicare

30.3% Medicaid

22.5% Uninsured

BY COUNTRY OF ORIGIN

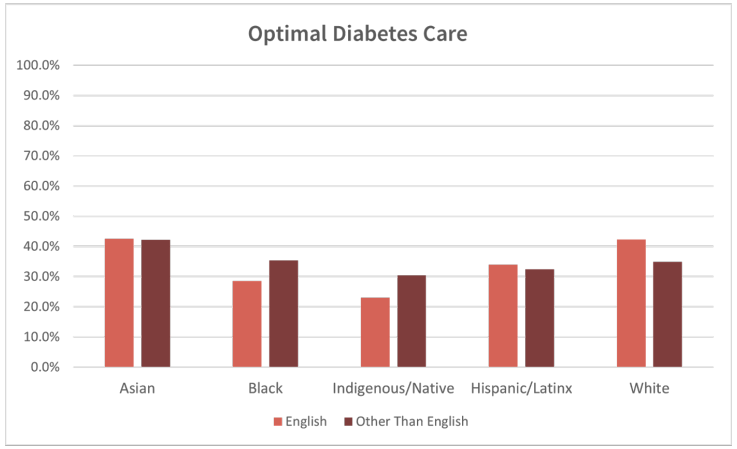


STATEWIDE RATES

38.3% Not U.S.-born

40.6% U.S.-born

BY PREFERRED LANGUAGE



STATEWIDE RATES

40.8% English

36.8% Other than English

GEOGRAPHIC ANALYSIS

HISTORIC APPROACH
and limitations

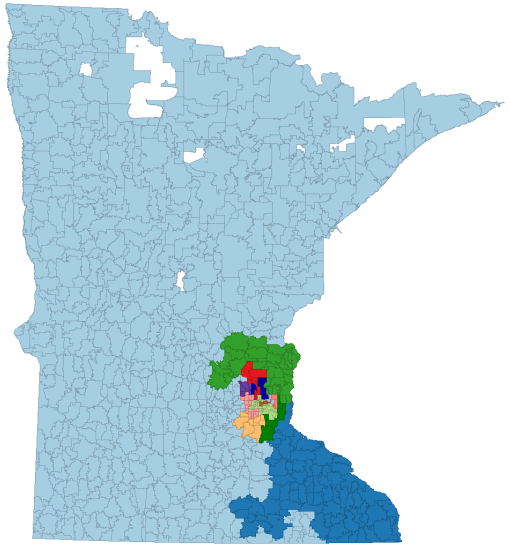
- 3-digit Zip code analysis
- Results generate small numbers
- Prevented publication of results for some geographies

EXPANDED APPROACH

- Defines regions as granular as possible while protecting patient privacy
- Ensures regions are large enough to produce valid results
- Provides deeper insights for region and population specific interventions

RACE AND ETHNICITY SPECIFIC GEOGRAPHIC AREAS

Optimal Diabetes Care
Asian patients



Region	Rate for Asian Patients	Region	Rate for Asian Patients
1	45.0%	8	46.0%
2	46.9%	9	43.8%
3	42.1%	10	45.2%
4	45.0%	11	34.6%
5	46.7%	12	39.1%
6	39.0%	13	35.2%
7	47.3%	14	37.4%

- Map shows distribution of Asian patients
- A minimum of five percent of the patients lives in each of the regions shown
- Table provides Optimal Diabetes Care results by region for Asian patients

KEY FINDINGS

Asian patients

Optimal Diabetes Care

Compared to statewide average:

Significantly higher rates of:

- Optimal Diabetes Care
- Being tobacco-free
- Statin use

Significantly lower rate of HbA1c control

AREAS OF OPPORTUNITY

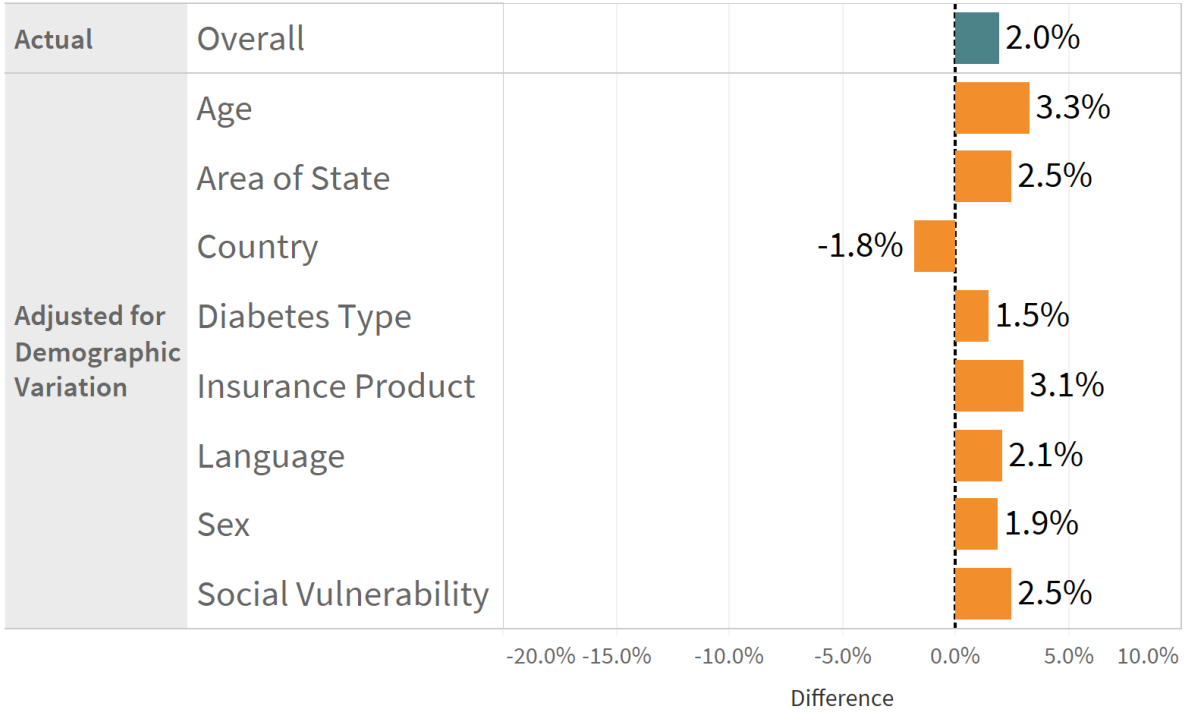
Among Asian patients, the rates of **HbA1c control** is significantly lower for:

- U.S.-born compared to non-U.S. born
- Non-English speakers compared to English-speakers
- Patients living in St. Paul compared to overall average for Asian patients

DEMOGRAPHIC IMPACT

Asian patients

Optimal Diabetes Care



KEY FINDINGS

Black patients

Optimal Diabetes Care

Compared to statewide average:

Significantly lower rates of:

- Optimal Diabetes Care
- HbA1c control
- Blood pressure control
- Being tobacco-free
- Statin use

AREAS OF OPPORTUNITY

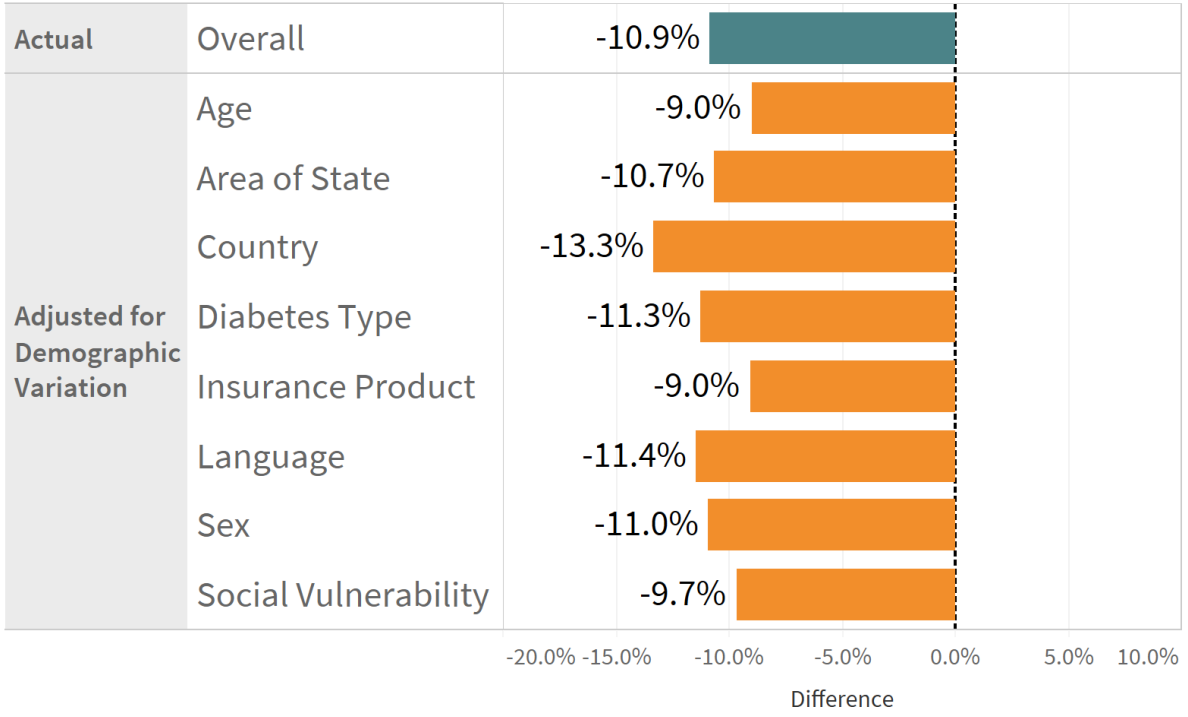
Among Black patients:

- The rate of **HbA1c control** is significantly lower for Type 1 diabetes compared to Type 2
- The rates of **blood pressure control** is significantly lower for:
  - U.S.-born compared to non-U.S. born
  - Non-English speakers compared to English-speakers

DEMOGRAPHIC IMPACT

Black patients

Optimal Diabetes Care



KEY FINDINGS

Indigenous/Native patients

Optimal Diabetes Care

Compared to statewide average:

Significantly lower rates of:

- Optimal Diabetes Care
- HbA1c control
- Being tobacco-free
- Statin use

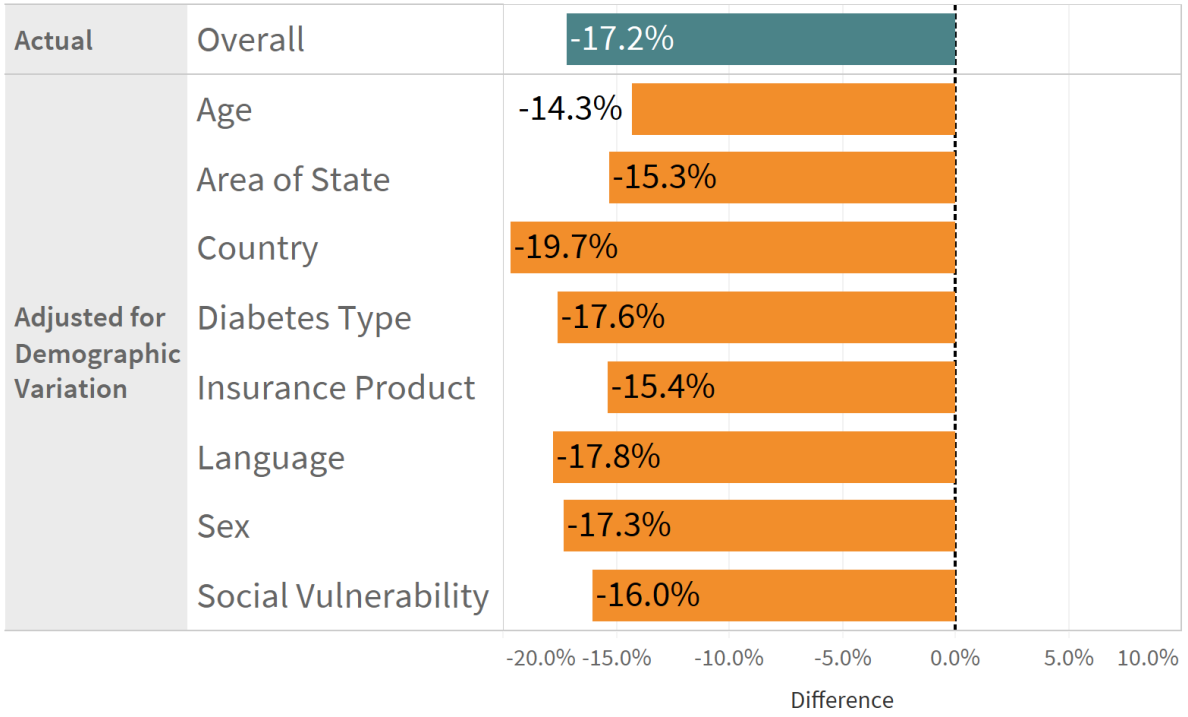
AREAS OF OPPORTUNITY

Among Indigenous/Native patients, the rates of **HbA1c control** and **being tobacco-free** are significantly lower than statewide average for almost all subpopulations

DEMOGRAPHIC IMPACT

Indigenous/Native patients

Optimal Diabetes Care



KEY FINDINGS

Hispanic/Latinx patients

Optimal Diabetes Care

Compared to statewide average:

Significantly lower rates of:

- Optimal Diabetes Care
- HbA1c control
- Statin use

AREAS OF OPPORTUNITY

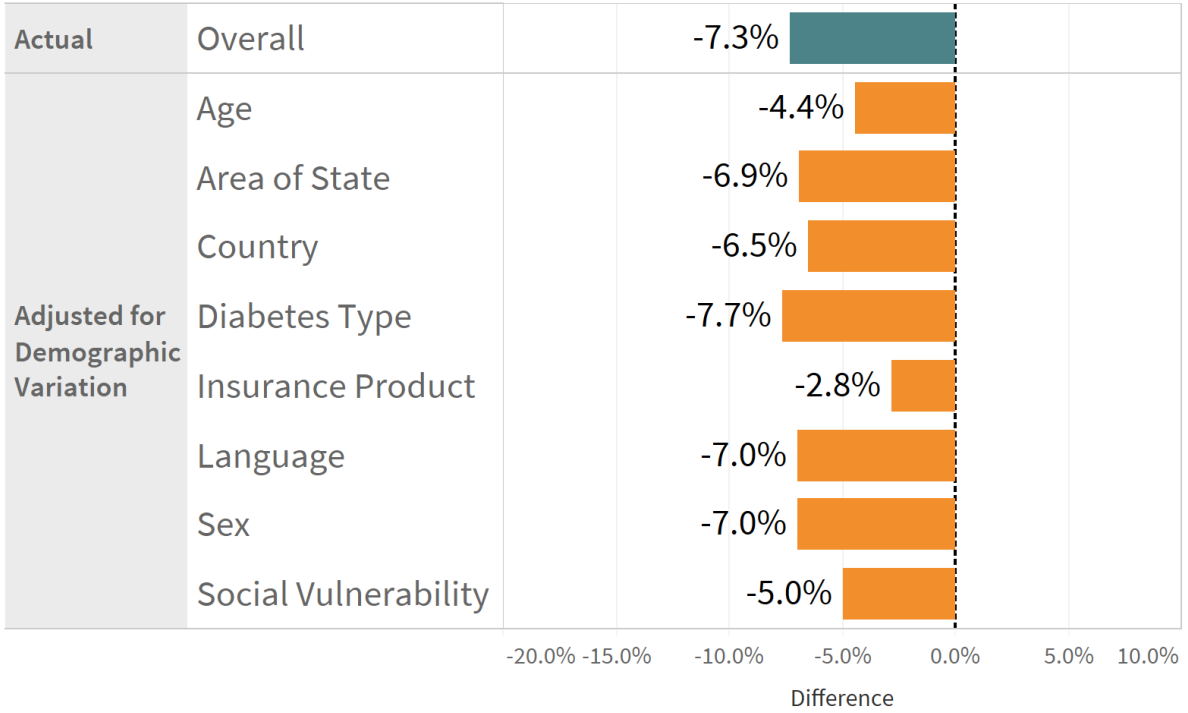
Among Hispanic/Latinx patients:

- The rate of **HbA1c control** is significantly lower for:
  - Both U.S.-born and those born outside the U.S. compared to statewide average
  - Both English-speakers and non-English speakers compared to statewide average
- The rate of **statin use** is significantly lower for:
  - Non-English speakers compared to statewide average
  - Patients born outside of the U.S. compared to statewide average

DEMOGRAPHIC IMPACT

Hispanic/Latinx patients

Optimal Diabetes Care



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- **Julie Sonier**

COMMUNITY ADVISORY GROUP

THE CHARGE

- ✓ Provide guidance to ensure project achieved goals
- ✓ Recommend how to translate analysis into action to address systemic racism and inequity

PRIORITIZATION FRAMEWORK

STRATEGIES FRAMEWORK

	WHAT						
WHO	Data and analysis	Payment models	Policy	Insurance coverage/ benefits	Patient education, engagement	Supports for individuals	Supports for communities
Health care providers							
Health plans							
Medicaid/state policy makers							
Federal policy makers							
Employers/ health care purchasers							
Public health							
Tribal organizations							
Community organizations							
Social services organizations							
Regional collaboratives (MNCM, Stratis Health)							

STAKEHOLDER SPECIFIC STRATEGIES


HEALTH CARE PROVIDERS


PUBLIC HEALTH


HEALTH PLANS


MEDICAID/STATE POLICY MAKERS


TRIBAL ORGANIZATIONS


SOCIAL SERVICES


COMMUNITY ORGANIZATIONS


EMPLOYERS/PURCHASERS


REGIONAL COLLABORATIVES

- Are the strategies actionable and feasible?
- What impact will they have?
- What are the top priorities likely to make the most difference?

STAKEHOLDER SPECIFIC STRATEGIES

HEALTH CARE PROVIDERS

- Collect social determinants of health (SDOH) data to better analyze impact on chronically ill patients.
- Provide culturally responsive care (e.g., diabetes self-management education with culturally appropriate food recommendations).
- Partner with communities to gain understanding of culture embedded in communities.

HEALTH PLANS

- Change pay-for-performance program goals from hitting improvement targets overall for measures to reducing disparities within those measures, as measured at the contract level.
- Drive grant making activities based on SDOH issues identified. Co-develop interventions with community organizations to reduce disparities and address SDOH needs.
- Work with health plan members who have been identified with care gaps to connect with their provider or connect them to a provider, if they do not have one. Assist members to obtain appointments as appropriate.

MEDICAID/STATE POLICY MAKERS

- Provide funding for community-based resources and other social needs interventions (e.g., housing, food, broadband, etc.).
- Include funding/payment for community organizations to address SDOH needs.
- Payment reform and include community health worker reimbursement in more robust ways.

STAKEHOLDER SPECIFIC STRATEGIES

EMPLOYERS/PURCHASERS

- Support wholistic care that includes addressing SDOH needs.
- Make patient engagement easy/accessible and include as work time.
- Require health plans to support activities to address SDOH needs.

PUBLIC HEALTH

- Link MNCM data with public health and other data sources to give broader picture.
- Partner with communities to gain understanding of culture embedded in communities.
- Provide population-level education on access, resources, etc.

TRIBAL ORGANIZATIONS

- Data provided to tribal organizations should include breakdowns of data by tribes and differences between populations living on tribal land.
- Develop and fund ways to increase staffing from Indigenous/Native populations to serve tribal populations.
- Payment reform and include community health worker reimbursement in more robust ways.

COMMUNITY ORGANIZATIONS

- Utilize data specific to the organization (e.g., who is served, how their services can make an impact, etc.).
- Utilize geographically-based linkages to public health and other community organizations to use data to make collective decisions around health activities in the community.
- Seek funding/payments necessary for community organizations to address SDOH needs.

STAKEHOLDER SPECIFIC STRATEGIES

SOCIAL SERVICES

- Provide intentional linkages with health systems around food, housing and other SDOH access.
- Utilize data specific to the organization (e.g., who is served, how their services can make an impact, etc.).
- Seek funding/payments necessary for social service organizations to address SDOH needs.

REGIONAL COLLABORATIVES

- Use data to identify organizations that are doing well at closing health equity gaps and engage them to share promising practices.
- Provide statewide analytics on social needs so that we can target social resources appropriately.
- Require representation from populations being impacted by disparities in all efforts at the policy level.

PRIORITY STRATEGIES TO ADDRESS HEALTH DISPARITIES

Data

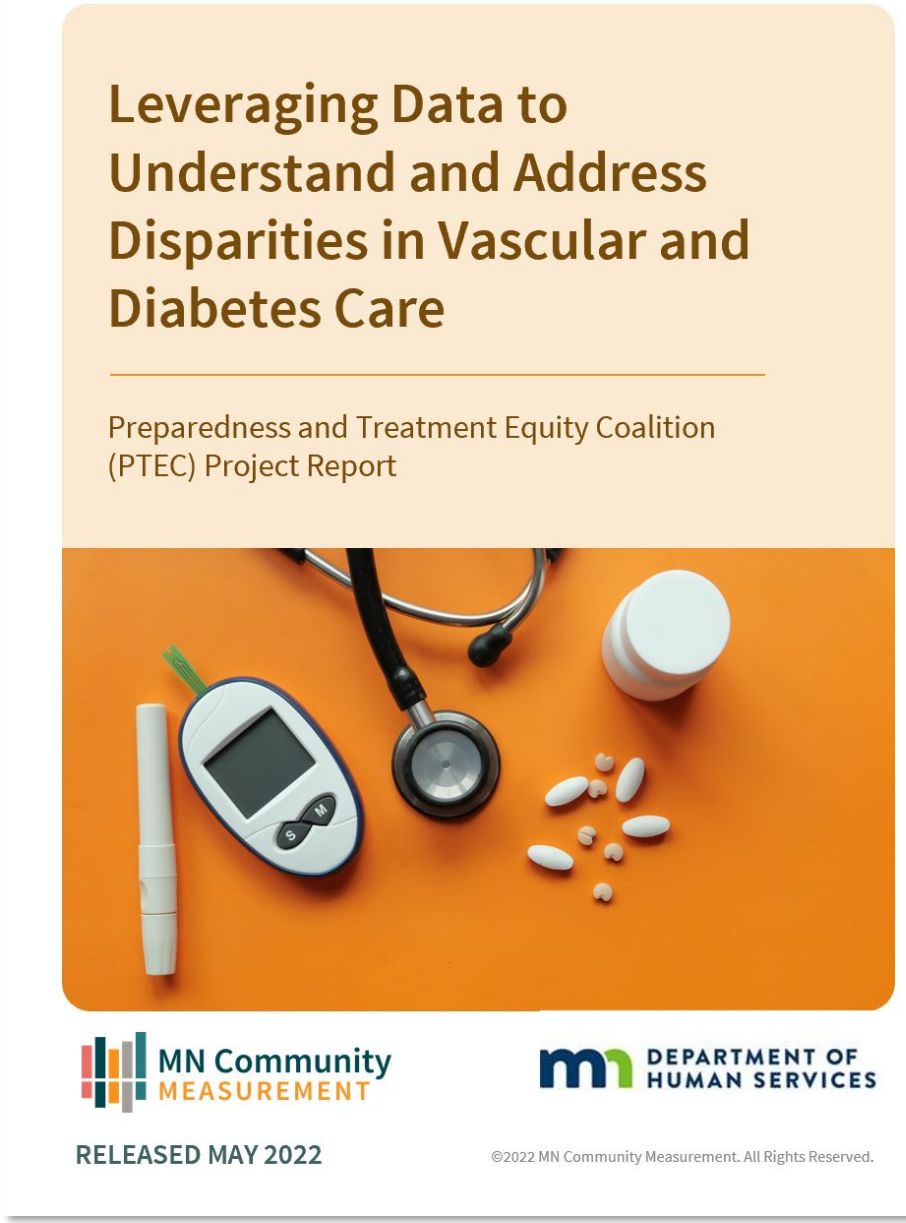
Access to data, especially SDOH data, to inform decisions on collective actions, funding of interventions, and evaluation of strategies

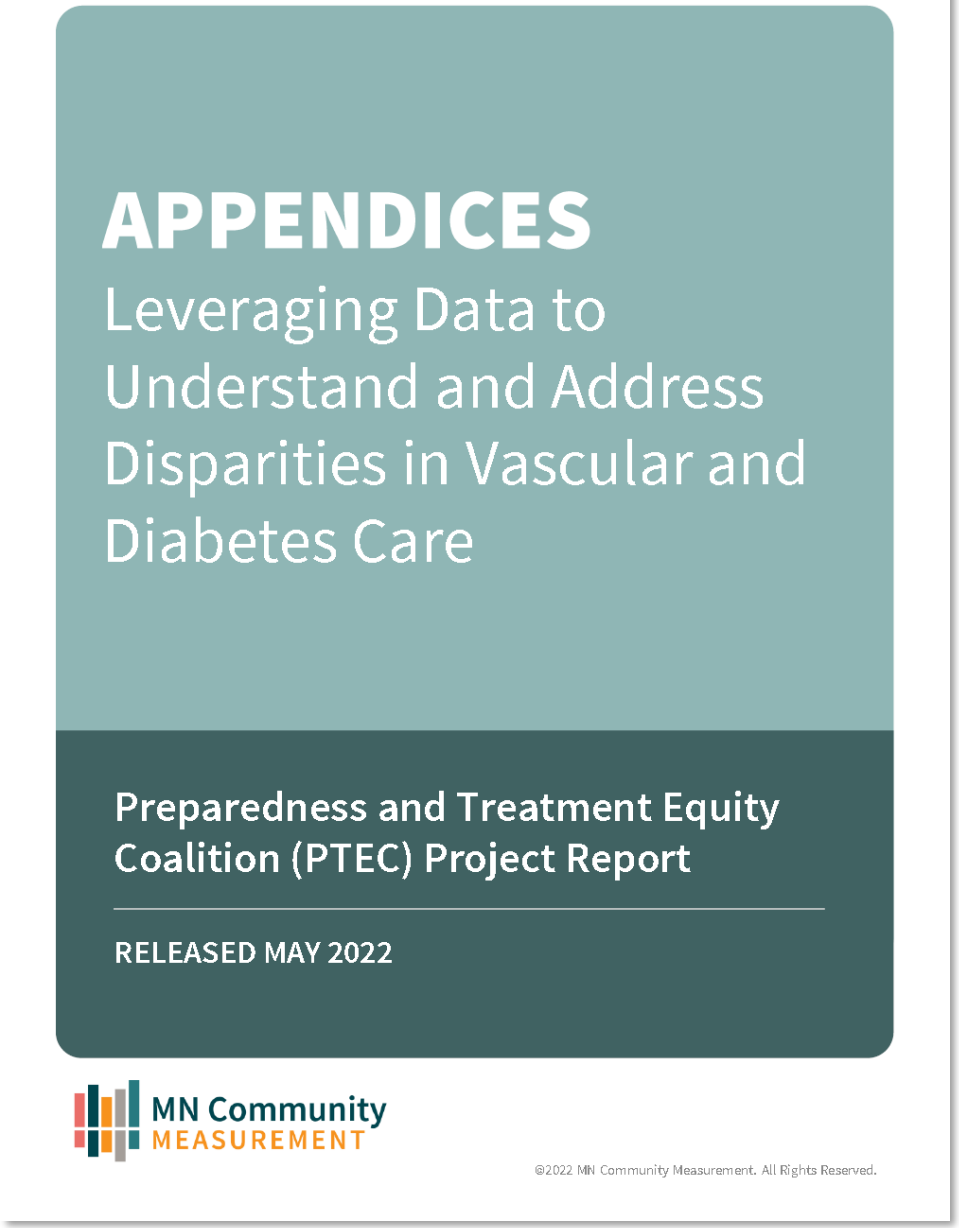
Community-informed Interventions

Using data, stakeholders can develop community-informed interventions and identify the resources available within communities to address SDOH needs

Collaboration

In order for strategies to be successful, it is imperative that collaboration and partnerships occur across stakeholders and within communities most impacted by disparities and social disadvantage





Available on mncm.org

Questions

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