WASHINGTON HEALTH ALLIANCE

Leading health system improvement

2015 Disparities in Care

Aiming for Health Equity in Washington State

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Disparities in Care: Aiming for health equity in Washington State. Washington Health Alliance, 2015.

Background

The focus on disparities in care is part of the Washington Health Alliance's continuing effort to identify and address disparities in Washington state. To produce this report, the Alliance stratified Medicaid claims data used to produce the 2014 Community Checkup; data was stratified by race, ethnicity, and language (REL). The REL categories are those selected and used by Medicaid, with each category representing many different population groups—likely representing huge variation among sub groups that is not represented in this report. Furthermore, the analysis currently only looks at the Medicaid-insured population because commercial plans in Washington state do not consistently capture REL data in a standardized way to allow for a comparison across the commercially insured population.

More information on the methods, population included and measure descriptions can be found at the end of this report.

Disparities in care: at the intersection of priorities

By focusing on reducing disparities, health providers, health plans and community organizations work to reduce variation while also providing care that is personalized and meaningful. Achieving equity in health care is essential to successfully achieve the Institute of Healthcare Improvement's Triple Aim—improving the experience of care, health of a population and per capita cost.

There are several areas where different health care sectors are beginning to rethink and prioritize disparities and health equity:

Population health management

- Through the population health lens, disparities in care can be seen as the failure—or success—of effective population health management. Organizations that work to address disparities also focus on breakdowns in the care process and thereby work to improve the care for all of their patients and community members. Focusing on disparities in care, therefore, is a key to addressing successful population health management.

Health disparities refer to the differences in health and health care received among groups of people. These differences can reveal how frequently a disease affects a group, whether a group receives appropriate care for their disease, or how often the disease causes disability or death. Some groups are more likely to be affected by disparities, including ethnic and racial minorities, women, children or the elderly or persons with disabilities.

Health equity, therefore, can be achieved when health disparities are eliminated and no one is disadvantaged from achieving their health potential from social, race or geographical circumstances.[1]

[1] *Centers for Disease Control and Prevention (2008). Promoting Health Equity: A resource to help communities address social determinants of health. http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/SDOH-workbook.pdf*

Demographic shift

- In 2010, approximately one third of the U.S. population are racial or ethnic minorities, and projections estimate that racial and ethnic minority populations will comprise a majority of the U.S. population by 2043.[2]
- Washington state is also experiencing unprecedented growth in language diversity. In the United States, Washington is one of only two states to be ranked as having both one of the largest Limited English Proficient (LEP) populations and also having one of the highest growth rates for LEP populations.[3]

Increased coverage

- Medicaid expansion offers a unique opportunity to increase coverage among low-income populations of which some racial and ethnic populations are disproportionately represented. The influx of the newly insured requires new strategies and approaches to providing meaningful, culturally and linguistically appropriate care to a more diverse patient population.

Organizational strategy

- From the increase in the number of pay-for-performance contracts to the increase in accreditation requirements now placed on provider and health plan organizations, working on health equity issues makes financial and organizational sense as well.

A call to action

The sooner health care organizations successfully address disparities in care, the better they will be positioned in the rapidly changing landscape of population health management and shifting demographics. Rather than creating a new initiative, successful strategies to improve disparities often involve incorporating a disparities-in-care "lens" throughout the organization. More strategies on how delivery systems can focus on disparities in care can be found in the resource section on page 17.

The following findings demonstrate that racial, ethnic and economic disparities are indeed a problem in Washington state. The Alliance hopes that these findings will provide a call to action that will lead to effective quality improvement efforts to improve the health of all the people in our state.

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[2] *U.S. Census Bureau (2010). State & County Quickfacts. Washington State. http://quickfacts.census.gov*

[3] *Migration Policy Institute (2011). LEP data brief. http://www.migrationpolicy.org/research/limited-english-proficient-individuals-united-states-number-share-growth-and-linguistic*

Key Findings: Accessing Care

Access to care measures look at utilization for patients who are enrolled in a health plan and who saw their health care provider during the measurement time period.

Having health insurance is important for individuals and families.[4] However, having insurance doesn't always mean you can see a provider or receive care when it's needed. Access to care measures looks at the utilization of primary care services across the state, which is especially valuable as we begin looking at the effects of Medicaid expansion. In other words, when people have insurance, does that mean they can go to the doctor?

INTERESTING FINDINGS

- Across all age groups, Medicaid enrollees access health care services *less* than commercial enrollees.
- Children between 2-19 years old have the lowest rates of accessing care, compared to other age groups. In fact, among Medicaid enrollees, children average between 12 to 20 percentage points worse than adults 45 years old and older.

Table 1. Accessing primary care among Medicaid and commercial enrollees, July 2012 - June 2013. Red=rate is significantly worse than Medicaid statewide rate; Green=significantly better; Gray=not significantly different. Color rankings based on Wilson Score Interval statistical test.

ACCESS TO CARE: *Percentage of patients who had a primary care visit during 2012-2013 measurement year*	Statewide Results		White	Hispanic/ Latino	Black/ African American	American Indian/ Alaska Native	Asian	Native Hawaiian/ Other Pacific Islander
	Commercial	Medicaid (all races)						
Ages 12–24 months	***89 %***	**84 %**	**82 %**	**90 %**	**87 %**	**42 %**	**89 %**	**87 %**
Ages 2–6 years	***78 %***	**70 %**	**67 %**	**78 %**	**71 %**	**31 %**	**78 %**	**68 %**
Ages 7–11 years	***81 %***	**78 %**	**77 %**	**82 %**	**79 %**	**36 %**	**85 %**	**76 %**
Ages 12–19 years	***81 %***	**74 %**	**77 %**	**73 %**	**77 %**	**37 %**	**82 %**	**74 %**
Ages 20–44 years	***90 %***	**82 %**	**82 %**	**84 %**	**83 %**	**81 %**	**81 %**	**75 %**
Ages 45–64 years	***95 %***	**90 %**	**90 %**	**90 %**	**91 %**	**87 %**	**90 %**	**90 %**
Ages 65+ years	***97 %***	**90 %**	**90 %**	**86 %**	*	*	**91 %**	*

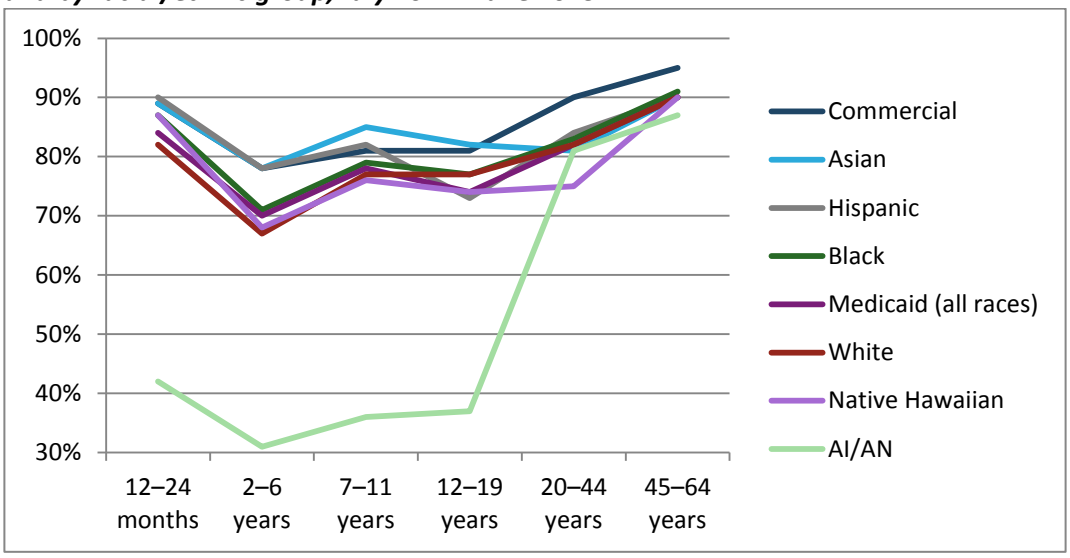
**Did not meet public reporting denominator minimum (<160) threshold requirements.*

[4] *Kaiser Family Foundation (2013). What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? http://kff.org/report-section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/*

INTERESTING FINDINGS: ACCESS TO CARE ACROSS AGE GROUPS

- Across all racial/ethnic groups, children between 2-6 years old have the lowest rates compared to other age categories.
- American Indian/Alaska Native (AI/AN) children aged 12 months to 19 years' experience markedly lower rates but have rates similar to other racial/ethnic groups for adults 20-64 years of age.

Figure 1. Accessing primary care among Medicaid enrollees, by age group and by racial/ethnic group, July 2012 - June 2013.

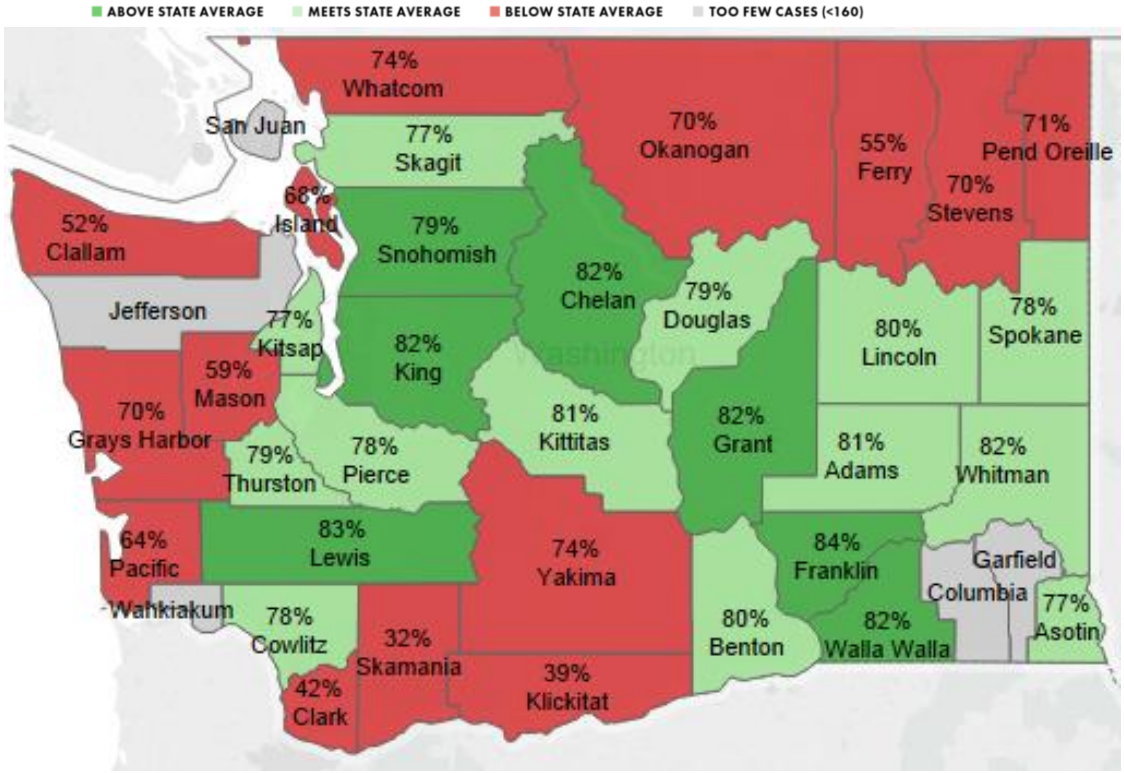


INTERESTING FINDINGS: ACCESSING PRIMARY CARE ACROSS COUNTIES

- The following county-level access to care results (map 1 on the next page) provides an example of the variation found across counties. For 7-11 year olds, the variation in accessing primary care is huge across Washington state, with a 52 percentage point difference from the highest and lowest performing counties (Franklin County, 84 percent, to Skamania County, 32 percent).

Map 1. Access to care among 7-11 year old Medicaid enrollees, county rates compared to Medicaid Statewide rate (78%), July 2012 – June 2013.

Color rankings based on Wilson Score Interval statistical test.



Health Screenings

Health screening measures are based on nationally agreed-upon standards of care for specific age groups. For example, colon cancer screenings for newly eligible patients 51-58 years of age, cervical screenings for women 24-64 years, breast screenings for women 52-69 years of age, and chlamydia screenings for women between 16-24 years of age.

Cancer screenings are important for early detection, reducing the risk of dying from cancer. This is especially important considering Washington's high rates of colon and breast cancers. In Washington state, colon cancer is not only the second most common cancer but is also the second leading cause of cancer deaths.[5] Breast cancer is a leading cause of cancer death for women in Washington. Washington not only has incidence rates for breast cancer that

[5] *Washington State Department of Health (2013). Health of Washington: Colorectal Cancer. http://www.doh.wa.gov/Portals/1/Documents/5500/CD-CCN2013.pdf*

are higher than the national average but Washington often ranks as one of the top 10 states in the country for newly diagnosed invasive breast cancers.[6]

INTERESTING FINDINGS

- Rates for colon cancer screenings are low across racial/ethnic groups, ranging from 37 to 44 percent. *That means that fewer than half of patients 51-58 years of age are receiving a recommended screening for the second leading cause of cancer in the state.*
- Breast and cervical screenings also represent big opportunities for improvement, with breast cancer screenings ranging from 41 to 58 percent and cervical screenings from 60 to 72 percent.
- Across all of the cancer screenings, Medicaid rates are worse than commercial rates, ranging from a 7 to 23 percentage points difference.
- For chlamydia screenings, Medicaid (50 percent) outperforms commercial (39 percent) statewide rates, which is the inverse for what is found among cancer screenings.

Table 2. Health screenings among Medicaid enrollees, July 2012 - June 2013.

Red=rate is significantly worse than Medicaid statewide rate; Green=significantly better; Gray=not significantly different. Color rankings based on Wilson Score Interval statistical test.

RACIAL/ETHNIC GROUP	*Cancer Screenings*			
	BREAST	CERVICAL	COLON	CHLAMYDIA
Statewide commercial	***73%***	***72%***	***60%***	***39%***
Statewide Medicaid (all races)	**50%**	**65%**	**43%**	**50%**
White	**50%**	**62%**	**43%**	**49%**
Hispanic or Latino	**53%**	**72%**	**42%**	**52%**
Black or African American	**49%**	**70%**	**43%**	**59%**
American Indian and Alaska Native	**41%**	**60%**	**37%**	**54%**
Asian	**58%**	**70%**	**44%**	**38%**
Native Hawaiian and Pacific Islander	*	**68%**	*	**46%**

*Did not meet public reporting denominator minimum (<160) threshold requirements.

In the United States, there is a high prevalence of chlamydia infections (6.8 percent) and chlamydia is the most commonly reported notifiable disease.

[6] *Washington State Department of Health (2013). Female Breast Cancer. http://www.doh.wa.gov/Portals/1/Documents/5500/CD-BCN2013.pdf*

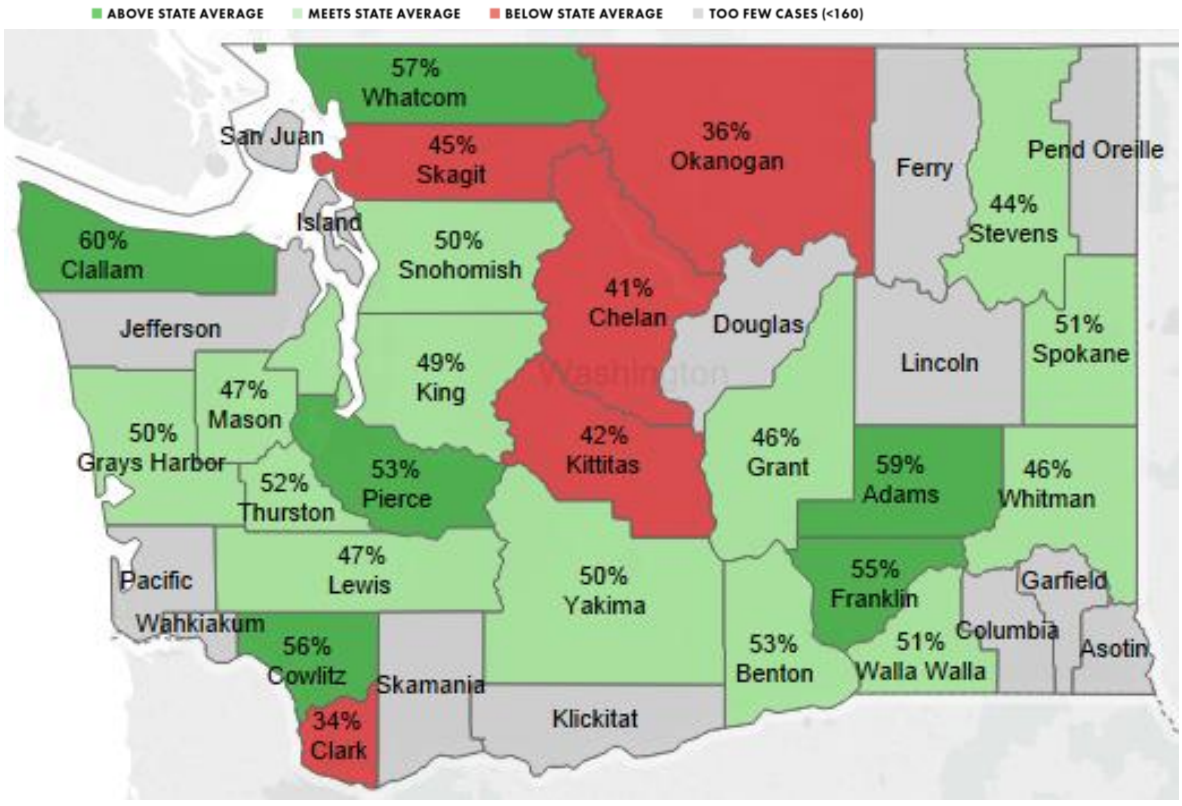
Chlamydia infections are sexually transmitted, are usually asymptomatic and can result in pelvic inflammatory disease that can have long term health impacts, such as infertility, ectopic pregnancy and chronic pelvic pain. Annual chlamydia screenings are recommended by the Center for Disease Control (CDC) for all sexually active women younger than 26 years of age because of the high prevalence and associated risks of the infection.[7]

INTERESTING FINDINGS: CHLAMYDIA

- Variation in chlamydia screening rates across the state is high, with a 26 percentage point difference across counties (Clallam County with 60 percent, to Clark County with 34 percent).
- With a low state rate of 50 percent for Medicaid enrollees, even the better performing counties have significant room for improvement.

Map 2. Health Screenings for Chlamydia, county rates compared to the statewide Medicaid rate (50%), July 2012 - June 2013.

Color rankings based on Wilson Score Interval statistical test.



[7] *Center for Disease Control (2012). Chlamydia: Sexually Transmitted Diseases Surveillance. http://www.cdc.gov/std/stats12/chlamydia.htm#foot5*

Diabetes Care

Diabetes measures look at how often patients with diabetes are receiving recommended care, including eye exams, kidney disease screening, and blood sugar and cholesterol testing, which are important for disease management.

Diabetes is the seventh leading cause of death in Washington state and effects over a half a million Washington residents. American Indians and Alaska Natives, Native Hawaiian and other Pacific Islanders, Blacks, Hispanics, Asians, and people in lower socioeconomic positions experience higher prevalence of diabetes than other groups.[8]

INTERESTING FINDINGS

- Across all four diabetes measures, American Indian and Alaska Native enrollees experience the lowest rates of any population and Asian enrollees experience the highest rates—even exceeding the commercial rate on three of the four measures.
- The diabetic eye exam measure has the lowest rates and has the largest variation across populations (25 percentage point difference).

Table 3. Quality of diabetes care among Medicaid enrollees, July 2012 - June 2013. Red= rate is significantly worse than Medicaid statewide rate; Green= significantly better; Gray=not significantly different. Color rankings based on Wilson Score Interval statistical test.

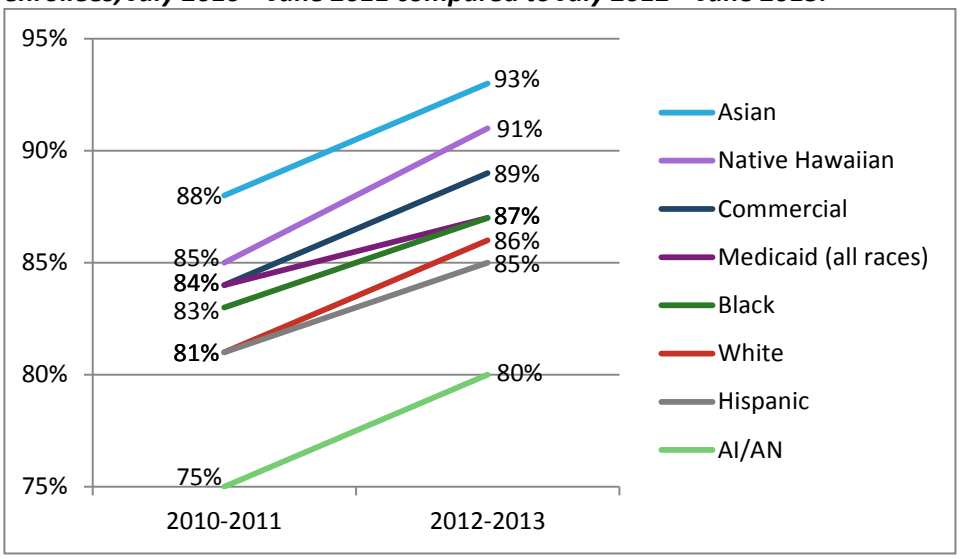
RACIAL/ETHNIC GROUP	***Diabetes***			
	Blood sugar (HbA1c) test	Cholesterol test (LDL-C or bad cholesterol)	Eye exam	Kidney disease screening
Statewide commercial	***89%***	***80%***	***63%***	***85%***
Statewide Medicaid (all races)	**87%**	**69%**	**55%**	**78%**
White	**86%**	**69%**	**55%**	**77%**
Hispanic or Latino	**85%**	**66%**	**54%**	**76%**
Black or African American	**87%**	**66%**	**55%**	**81%**
American Indian and Alaska Native	**80%**	**65%**	**41%**	**74%**
Asian	**93%**	**79%**	**66%**	**87%**
Native Hawaiian and Pacific Islander	**91%**	**74%**	**62%**	**84%**

[8] *Washington State Department of Health (2013). Diabetes. http://www.doh.wa.gov/Portals/1/Documents/5500/CD-DIAB2014.pdf*

INTERESTING FINDINGS: DIABETIC BLOOD SUGAR TESTING

- In comparing the results for blood sugar tests to the first disparities report (2010-2011 data), all populations have improved between three to six percentage points.
- Though rates are improving, disparities by race/ethnicity still remain high, with a 13 percentage point difference from the best (93 percent) and lowest rates (80 percent).

Figure 2. Diabetes care over time: Blood sugar (HbA1c) tests among Medicaid enrollees, July 2010 – June 2011 compared to July 2012 – June 2013.



Generic Prescription Drugs

These measures look at the percentage of generic drugs prescribed when common medications are needed that have well-established generic options. Increasing the use of generic drugs when appropriate increases affordability for patients, which is an important contributor to adherence to medication as prescribed.

Generic prescription drugs often have the same safety and strength as their brand-name drug counterparts and, for most people, work as well as brand-name drugs. Generic prescription measures look at how clinics and communities approach ways to control costs, as well as quality issues as patients may be more likely to adhere to their recommended drug regimen if the medicine is more affordable.

INTERESTING FINDINGS

- Across all of the measures, the statewide Medicaid rates perform better than commercial statewide rates.
- High rates with little variation can be seen in generics for high blood pressure, with a consistently high rate across all Medicaid populations (96 to 98 percent).
- Biggest room for improvement is in Attention Deficit Hyperactivity Disorder (ADHD) generics, where rates are around 20 percentage points below the other generic rates.

Table 4. Generic prescriptions among Medicaid enrollees, July 2012 - June 2013. Red=rate is significantly worse than Medicaid statewide rate; Green=significantly better; Gray=not significantly different. Color rankings based on Wilson Score Interval statistical test.

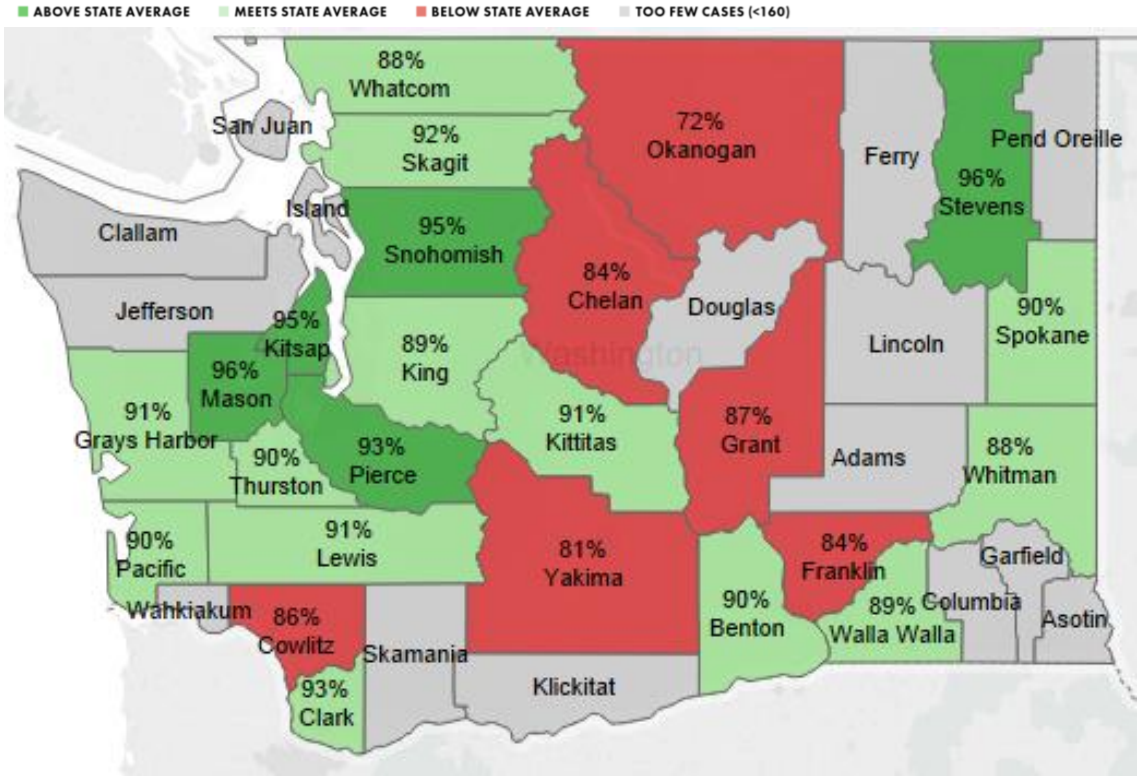
RACIAL/ETHNIC GROUP	*Generic Prescription Drugs*				
	Antacid medication (proton pump inhibitors or PPIs)	Antidepressants (SSRIs and second generation antidepressants)	Cholesterol-lowering drugs (statins)	Medication for high blood pressure (ACE inhibitors or ARBs)	Medication for attention deficit hyperactivity disorder
Statewide commercial	***87%***	***94%***	***88%***	***92%***	***70%***
Statewide Medicaid (all races)	**94%**	**96%**	**90%**	**97%**	**76%**
White	**95%**	**95%**	**89%**	**97%**	**75%**
Hispanic or Latino	**92%**	**96%**	**89%**	**98%**	**78%**
Black or African American	**96%**	**96%**	**91%**	**97%**	**79%**
American Indian and Alaska Native	**91%**	**92%**	**90%**	**97%**	**77%**
Asian	**93%**	**99%**	**94%**	**96%**	**72%**
Native Hawaiian and Pacific Islander	**93%**	**99%**	**95%**	**96%**	**78%**

INTERESTING FINDINGS: GENERIC PRESCRIPTION RATES FOR CHOLESTEROL LOWERING DRUGS

- The following map for statin generics demonstrates how even a relatively high statewide rate of 90 percent for Medicaid enrollees can still leave room for improvement.
- Variation across counties continues to be high, with a 24 percentage point difference from the highest to lowest performing county (96 percent in Stevens and Mason counties, to 72 percent in Okanogan County).

Map 3. Generic prescriptions for cholesterol-lowering drugs (statins) among Medicaid enrollees (90%), July 2012 – June 2013.

Color rankings based on Wilson Score Interval statistical test.



Language barriers

The following language categories are those used by Medicaid during enrollment to capture language preferences among enrollees. The below categories certainly only touch the surface of languages used, however the information can provide a broad stroke view of how care may differ according to language preference.

The effectiveness of communication between patients and their providers can have a major effect on quality and health outcomes. Limited English proficiency can be a barrier to effective communication, making patients less likely to seek and receive needed care, and raise costs.[9]

[9] *Brach C, Fraser I, and Paez K. (2005). Crossing the Language Chiasm. Health Affairs. 24:(2); 424-434.*

INTERESTING FINDINGS: LANGUAGE AND ACCESSING PRIMARY CARE

- Enrollees who self-selected Spanish, Asian and Pacific Island, or other languages do well on many of the access to care measures, including having higher rates than English and Other Indo-European languages.
- The biggest room for improvement is among Other Indo-European language speakers.

Table 5. Access and quality of care, stratified by language for Medicaid enrollees, July 2012 - June 2013. Red rate is significantly worse than Medicaid statewide rate; Green=significantly better; Gray=not significantly different. Color rankings based on Wilson Score Interval statistical test.

QUALITY MEASURE	Statewide Medicaid (all languages)	English	Spanish	Other Indo-European languages	Asian and Pacific Island Languages	Other languages
Access to care						
Child & adolescent access to primary care - Ages 12–24 months	**84%**	**82%**	**92%**	**70%**	**92%**	**93%**
Child & adolescent access to primary care - Ages 2 – 6 years	**70%**	**68%**	**83%**	**59%**	**84%**	**83%**
Child & adolescent access to primary care - Ages 7–11 years	**78%**	**76%**	**84%**	**74%**	**88%**	**85%**
Child & adolescent access to primary care - Ages 12–19 years	**74%**	**75%**	**70%**	**75%**	**83%**	**82%**
Adult access to preventive/ambulatory care - Ages 20–44 years	**82%**	**82%**	**88%**	**67%**	**81%**	**84%**
Adult access to preventive/ambulatory care - Ages 45-64 years	**90%**	**90%**	**89%**	**85%**	**92%**	**93%**
Adult access to preventive/ambulatory care - Ages 65+ years	**90%**	**89%**	**88%**	**94%**	**91%**	**91%**

INTERESTING FINDINGS: DIABETES AND HEALTH SCREENINGS

- Enrollees who selected Other Indo-European, Asian and Pacific Island, and Other language categories did well on diabetic care measures, and have better rates than Spanish and English speakers.
- Enrollees who selected Spanish as their primary language had better than average rates on breast cancer screenings, and for the cervical cancer screening measure Spanish speakers outperform all other language groups.
- Most language groups have room for improvement in health screening measures, particularly in chlamydia screenings.

Table 6. Quality of diabetes care and health screenings, stratified by language for Medicaid enrollees, July 2012–June 2013. Red=rate is significantly worse than Medicaid statewide rate; Green=significantly better; Gray=not significantly different. Color rankings based on Wilson Score Interval statistical test.

QUALITY MEASURE	Statewide Medicaid (all languages)	English	Spanish	Other Indo-European languages	Asian and pacific island languages	Other languages
Diabetes						
Blood sugar (HbA1c) test	87%	86%	88%	95%	91%	94%
Cholesterol test (LDL-C or bad cholesterol)	69%	68%	60%	88%	83%	81%
Eye exam	55%	54%	55%	64%	68%	69%
Kidney disease screening	78%	78%	74%	92%	89%	84%
Health screenings						
Screening for breast cancer- ages 52-69 years	50%	50%	62%	49%	60%	48%
Screening for cervical cancer	65%	64%	78%	56%	66%	65%
Screening for chlamydia	50%	50%	42%	31%	25%	36%
Screening for colon cancer	43%	43%	50%	42%	45%	41%

Summary look across all measures: Comparing care for Medicaid and commercial enrollees

Comparing care received by Medicaid and commercial enrollees provides an important view into how different socioeconomic groups are receiving care.

Medicaid provides health coverage to low-income children and adults who lack access to private health insurance. Its enrollees have a distinctly higher rate of poverty, chronic illness, and disability than the commercially insured population. Medicaid increases access to care, health care use and lowers costs.[10]

[10] *Kaiser Family Foundation (2013). What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? http://kff.org/report-section/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/*

Table 7. Medicaid enrollees compared to commercially-insured populations, July 2012–June 2013. Red=Medicaid statewide rate is significantly worse than commercial statewide rate; Green=significantly better; Gray=not significantly different. Color rankings based on a Chi Square* statistical test, P-value= 0.05. **Note: Tables 7-8 use a different test from previous tables.*

QUALITY MEASURE *(measure descriptions can be found on page 19-20)*	Statewide Medicaid Rate	Statewide Commercial Rate
Health screenings		
Adolescent well-care visits – Ages 12-21 years	**33%**	**37%**
Screening for breast cancer - Ages 52–69 years	**50%**	**73%**
Screening for cervical cancer – Ages 21-64 years	**65%**	**72%**
Screening for chlamydia – Ages 16-25 years	**50%**	**39%**
Screening for colon cancer – Ages 51-57 years	**43%**	**60%**
Access to care		
Child & adolescent access to primary care - Ages 12–24 months	**84%**	**89%**
Child & adolescent access to primary care - Ages 2–6 years	**70%**	**78%**
Child & adolescent access to primary care - Ages 7–11 years	**78%**	**81%**
Child & adolescent access to primary care - Ages 12–19 years	**74%**	**81%**
Adult access to preventive/ambulatory care - Ages 20–44 years	**82%**	**90%**
Adult access to preventive/ambulatory care - Ages 45–64 years	**90%**	**95%**
Adult access to preventive/ambulatory care - Ages 65+ years	**90%**	**97%**
Diabetes		
Blood sugar (HbA1c) test – Ages 18-75 years	**87%**	**89%**
Cholesterol test (LDL-C or bad cholesterol) – Ages 18-75 years	**69%**	**80%**
Eye exam – Ages 18-75 years	**55%**	**63%**
Kidney disease screening – Ages 18-75 years	**78%**	**85%**
Asthma		
Use of appropriate medication – Ages 5-50 years	**84%**	**92%**
Chronic obstructive pulmonary disease (COPD)		
Use of spirometry testing in assessment and diagnosis of COPD - Ages 40+ years	**32%**	**47%**
Depression		
Antidepressant medication (12 Weeks) – Ages 18+ years	**58%**	**71%**
Antidepressant medication (6 Months) – Ages 18+ years	**43%**	**55%**

Table 8. Medicaid enrollees compared to commercially-insured populations, July 2012 – June 2013. Red=Medicaid statewide rate is significantly worse than commercial statewide rate; Green=significantly better; Gray=not significantly different. Color rankings based on a Chi Square* statistical test, P-value= 0.05. **Note: Tables 7-8 use a different test from previous tables.*

QUALITY MEASURE *(measure descriptions can be found on page 19-20)*	Statewide Medicaid Rate	Statewide Commercial Rate
Heart disease		
Cholesterol test (LDL-C or bad cholesterol) – Ages 18-75 years	**73%**	**76%**
Cholesterol-lowering medication– Ages 18-75 years	**73%**	**76%**
Appropriate use of care		
Avoidance of antibiotic treatment in adults w/ acute bronchitis – Ages 18-64 years	**22%**	**27%**
Avoidance of antibiotics for common cold – Ages 18-64 years	**91%**	**91%**
Avoidance of X-ray, MRI & CT scan for low back pain – Ages 18-64 years	**85%**	**86%**
Use of generic prescription drugs		
Antacid medication (Proton Pump Inhibitors)	**94%**	**87%**
Antidepressants	**96%**	**94%**
Cholesterol-lowering drugs (Statins)	**90%**	**88%**
Medication for ACE inhibitors or angiotensin II receptor blockers (ARBs) used to treat high blood pressure	**97%**	**92%**
Medication for attention deficit hyperactivity (ADHD)	**76%**	**70%**

Resources

Recommended reading to learn more about disparities in care and health equity issues.

- **Achieving Health Equity by Design.** This viewpoint, published by the *Journal of the American Medical Association* in 2015, recommends new tools and approaches to addressing disparities, including financial rewards for improved outcomes and redesigning services to achieve equity. Available at: *http://jama.jamanetwork.com/article.aspx?articleid=2195960&elq_cid=1671896*

- **A Roadmap and Best Practices for Organizations to Reduce Racial and Ethnic Disparities Care:** This article, published in the *Journal for General Internal Medicine* in 2012, summarizes current knowledge from the field of disparities intervention research, and provides a six-step framework for incorporating equity into quality improvement efforts. Available at: *www.ncbi.nlm.nih.gov/pmc/articles/PMC3403142/pdf/11606_2012_Article_2082.pdf*
- ***Unequal Treatment (Institute of Medicine):*** The 2002 report finds that a consistent body of research demonstrates significant variation in the rates of medical procedures by race, even when insurance status, income, age, and severity of conditions are comparable. This research indicates that U.S. racial and ethnic minorities are less likely to receive even routine medical procedures and experience a lower quality of health services. Available at: *www.iom.edu/Reports/2002/Unequal-Treatment-Confronting-Racial-and-Ethnic-Disparities-in-Health-Care.aspx*

About the data

The Medicaid population in this report represents those who had full Medicaid insurance benefits in the measurement year of July 1, 2012 to June 30, 2013, and who qualified for Medicaid due to their low income, rather than those eligible due to a disability or high medical need. Medicaid clients who were not eligible for full coverage (such as family planning-only services), those who qualified based on medical need (blind, disabled, medically needy), and/or those who had other payer sources (such as Medicare) were not included in the study. Of the nearly 1.3 million Medicaid enrollees in the Alliance's data base, 680,271 met the measure criteria.

Medicaid data limitations include possible underreporting of claims by managed care plans and no reporting of services received outside of Medicaid, such as those from free clinics in the community or tribal clinics. The data has been stratified by race, ethnicity, and language (REL). Findings were not adjusted for differences in age and gender distribution, except for those measures reported by age group and gender. Denominators lower than 160 are suppressed and indicated in the report with an asterisk. A Wilson Score Interval test, using a 95 percent confidence interval, was used to show statistically significance between variables.

Understanding the measures

More on the measure specifications used in the Community Checkup and Disparities in Care reports.*

Access

- Child and Adolescent Access to Primary Care, for ages 12 months to 19 years: measures the percentage of children ages of [specified age range] that had a visit with a primary care practitioner in the past year.
- Adult access to preventive/ambulatory care, ages 20 to 64 years: For commercially insured adults ages of [specified age range], this measures those who had a preventive care visit within the past three years. For Medicaid-insured adults ages of [specified age range], this measures those who had a preventive care visit within the past year.

Appropriate Use of Care

- Avoidance of Antibiotic treatment for Acute Bronchitis: measures the percentage of adults ages 18 to 64 diagnosed with acute bronchitis who were not dispensed an antibiotic prescription on of for three days after diagnosis.
- Avoidance of Antibiotics for Common Cold: measures the percentage of children ages 18 months to 18 years who went to the doctor for a common cold who were prescribed an antibiotic for three days after the diagnosis.
- Avoidance of Imaging for Low Back Pain: measures the percentage of patients ages 18 to 50 with a new diagnosis of low back pain who did not have any x-ray, or other imaging study (MRI, CT Scan) in the 28 days after they first visited a health care provider due to low back pain.

Diabetes Care

- Blood Sugar: measures the percentage of patients ages 18 to 75 diagnosed with diabetes (type 1 and type 2) whose blood sugar was tested using a HbA1c test by a doctor or other health care provider at least once in the one-year measurement period.
- Cholesterol Test: measures the percentage of patients ages 18 to 75 with diabetes (type 1 and type 2) who had a test for Low Density Lipoprotein cholesterol (LDL-C or "bad" cholesterol) at least once during the one-year measurement period.
- Eye Exam: measures the percentage of patients ages 18 to 75 diagnosed with diabetes (type 1 and type 2) that had an eye exam at least once in a two-year period or, if there is evidence of eye disease, during a one-year period.
- Kidney Disease Screening: measures the percentage of patients ages 18 to 75 with diabetes (type 1 and type 2) who had a kidney screening (urine microalbumin) test or were treated for kidney disease (nephropathy) or who have already been diagnosed with kidney disease, at least once during the one-year measurement period.

Generic Prescription Drugs

- Proton Pump Inhibitors: measures the percentage of prescriptions for antacids to reduce chronic stomach or gastric acid (proton pump inhibitors or PPIs) that were filled with a generic PPI anytime during the one-year measurement period.
- Antidepressants: measures the percentage of prescriptions for antidepressant drugs (all second generation antidepressants) that were filled with a generic antidepressant anytime during the one-year measurement period.

- Cholesterol-Lowering Drugs (Statins): measures the percentage of all prescriptions for cholesterol-lowering drugs (statins) that were filled with a generic drug rather than a brand-name drug anytime during the one-year measurement period.
- Medication for high Blood Pressure (Antihypertensives): measures the percentage of prescriptions for certain antihypertensive drugs (ACE inhibitors and ARBs) that were filled with a generic antihypertensive anytime during the one-year measurement period.
- Attention Deficit Hyperactivity Disorder Drugs: measures the percentage of prescriptions for certain ADHD drugs that were filled with a generic drug rather than a brand name drug anytime during the one-year measurement period.

Asthma

- Asthma: measures the percentage of patients ages 5 to 50 who were identified as having persistent asthma and who were appropriately prescribed long-term controller medication(s) during the measurement year.

Chronic Obstructive Pulmonary Disease (COPD)

- COPD: measures the percentage of patients ages 40 and older with a new diagnosis of COPD who had appropriate spirometry testing to confirm diagnosis.

Heart Disease

- Cholesterol Test: measures the percentage of patients ages 18 to 75 who had at least one LDL cholesterol screening test in the year after they were discharged from the hospital for the following heart procedures or conditions: acute myocardial infarction (heart attack), coronary artery bypass graft, percutaneous transluminal coronary angioplasty, or stroke or aneurysm (ischemic vascular disease).
- Cholesterol-Lowering Medication: measures the percentage of patients ages 18 to 75 with coronary artery disease (heart disease) who had at least one prescription filled to lower cholesterol during a one-year period.

Depression

- Antidepressant Medication (12 weeks): measures the percentage of patients 18 years and older who were newly diagnosed with depression who were prescribed an antidepressant medication, and remained on an antidepressant during the entire 12 weeks after the diagnosis (i.e. Acute Treatment Phase).
- Antidepressant Medication (6 months): measures the percentage of patients 18 years and older who were newly diagnosed with depression and who were prescribed an antidepressant medication drug and continued taking an antidepressant for at least 180 days (6 months).

Health Screenings

- Adolescent Well-Care visits: measures the percentage of adolescents ages 12–21 years who had a well-care visit with a primary care practitioner in the past year.
- Screening for chlamydia: measures the percentage of women ages 16 to 25 who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
- Screening for breast cancer: measures the percentage of women ages 52 to 69 who had at least one mammogram to screen for breast cancer during the two-year period measured.
- Screening for cervical cancer: measures the percentage of women ages 21 to 64 who received one or more Pap tests to screen for cervical cancer within the past three years.
- Screening for colon cancer: measures the percentage of adults ages 51–57 who had appropriate screening for colon or colorectal cancer.

** Most measures are modified NCQA HEDIS measures. Detailed specifications can be found at:*
http://wacommunitycheckup.org/Media/Default/Documents/community_checkup_technical_specifications.pdf

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WASHINGTON HEALTH ALLIANCE

ABOUT THE WASHINGTON HEALTH ALLIANCE

The Washington Health Alliance is a place where stakeholders work jointly to transform Washington's health care system for the better. The Alliance brings together organizations that share a commitment to drive change in our health care system by offering a well-respected and established forum for critical conversation and collective impact through alignment of work underway in Washington by key stakeholders: employers, union trusts, medical groups, hospitals, health plans, other health care partners and consumers. The Alliance believes strongly in transparency, and works diligently to offer trusted and credible reporting of progress on key measures of health care quality and value. The Alliance is a private, non-profit (501c3) in the state of Washington with over 185 member organizations.

For more about the Alliance:
www.WashingtonHealthAlliance.org

For the Community Checkup report:
www.WACommunityCheckup.org