Meeting Notes

The fifth meeting of the Social Justice & Health Disparities Working Group was held on March 25, 2021 from 3:00-4:30pm.

Dr. Dora Hughes began the meeting with a brief follow-up presentation to last week's presentation on Racial and Ethnic Data Collection. Dr. Hughes reiterated the importance of collecting racial and ethnic data to identify disparities and inform the allocation of health care resources and the development of interventions. She noted that the Office of Management and Budget (OMB) has developed standards for racial and ethnic data collection that are adhered to at the federal level and by many organizations in the private sector. During last week's presentation, a question was raised about why it is important to collect detailed race and ethnicity data, and Dr. Hughes described how each primary race and ethnicity group encompasses many subgroups. Disaggregating this data may expose significant differences in the incidence and prevalence of certain conditions among different subgroups.

Dr. Cara James then provided additional information on the COVID Equity Task Force and its focus on data collection in the context of the pandemic. She emphasized the importance of racial and ethnic data collection and provided two examples: 1) there is significant variation in infant mortality within Hispanic and Latino subgroups, and 2) there is variation in income, employment, health insurance rates, and health literacy within Asian subgroups. In addition, HHS, as required by the ACA, disaggregated racial and ethnic subgroup data for Asian Americans, Native Hawaiian and Other Pacific Islanders, and Hispanics, and this data collection strategy has been incorporated into the application for the health insurance exchanges.

Stacey Shapiro on Kaiser Permanente's Initiatives to Advance Equity

Our first guest speaker this week, Stacey Shapiro, is Director of Population Care Management in the mid-Atlantic region for Kaiser Permanente.

Kaiser Permanente's approach to closing clinical quality disparities starts with the executive leadership and an infrastructure commitment to support these goals. Data collection is a priority, and as an integrated delivery system they are able to collect this data through direct methods, such as by asking patients during clinical encounters. Stacey noted that years ago they used demographic data to identify gaps in performance and found that age was one of the greatest drivers of performance disparities. Some of the performance gaps they continue to track by age and/or race include glycemic control, blood pressure control, depression screening, and child immunizations before age 2.

Kaiser Permanente is also working to address social determinants of health through their Thrive Local program, which connects health and social service providers to better coordinate and improve patient care. The program launched for Mid-Atlantic States in 2020.

In regard to workforce, Kaiser Permanente is committed to hiring a diverse workforce and provides ongoing training opportunities related to bias. They also have a qualified bilingual staff program to assist with interpretation.

Stacey discussed how Kaiser Permanente works to engage health plan members through a variety of strategies (in English and Spanish), including providing virtual educational programs, after-visit summaries, printed health education materials, and videos and Facebook Live sessions on a variety of topics. Providers do universal depression screening as part of every office visit, and they offer telephonic no-copay health coaching for tobacco cessation, weight management, physical activity, and stress management. They have updated some of their forms to be more inclusive of the LGBTQ+ population, including providing space for members to document their preferred name and other relevant information related to gender identity.

Kaiser Permanent has an escalation process for interventions that starts with sending secure messages (in English or Spanish) to members due for care, followed by letters, texts, and then phone calls. Stacey noted that in the past year they have made a concerted effort to engage members in their diabetes care by having primary care physicians call them in English or Spanish.

Stacey emphasized that Kaiser Permanente's strategy is to create systems that make it easier for people to get care, and convenience has become particularly important during the pandemic. Prior to the pandemic, they utilized virtual visits and had 24/7 lab and pharmacy availability. In response to COVID, they offer "drive through" phlebotomy and flu shots, and send colon cancer screening fit kits directly to homes.

Mike Currie on UnitedHealth Group's Initiatives to Advance Equity

Our second guest speaker this week, Mike Currie, is the Chief Health Equity Officer for UnitedHealth Group (UHG).

UHG supports efforts to identify, address, and monitor health disparities associated with age, gender, address, race and ethnicity, language, and disability. Their commitment to achieving health equity serves as the foundation for their efforts to offer culturally competent care management services to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. In 2010, UHG founded the Health Equity Services Program, which works with leaders to use data to identify gaps in access, care and/or outcomes, and then develop tailored materials and interventions based on members' cultural beliefs and behaviors, aimed at reducing health disparities and enhancing the end-to-end consumer experience.

Mike then reviewed various types of efforts that work to advance health equity, including addressing health disparities, social determinants of health, inclusion and diversity, health literacy, cultural competency and bias training, supplier diversity, research and development, and

social responsibility. Other efforts to advance health equity relate to member satisfaction improvement, affordability, and costs (to reduce and eliminate avoidable costs).

UHG's core efforts to acknowledge and support the impact that culturally competent care has on improving health outcomes include:

- Analytics: integrating member age, gender, address, race/ethnicity and language data with clinical data to identify any disparities in care that are associated with the aforementioned member demographics
- Cultural competence: providing clinical and non-clinical cultural competency training to staff to create an awareness of the unique needs of members from various cultures, resulting in the delivery of more personalized service
- Outreach: customizing member materials and engagement strategies based on identified unique cultural needs and gaps in care
- Providers: fostering culturally competent care by our contracted providers.

Mike emphasized that health is impacted more by SDOH than clinical performance, and UHG works to identify where these SDOH exist within member population, offer resources and support to address those SDOH, and discuss health behaviors and compliance.

Some examples of UHG's health equity efforts include addressing disparities in maternal health outcomes, creating health disparities action plans, achieving the NCQA Multicultural Health Care Distinction, advancing health equity education (web-based), hosting a virtual LGBTQ+ support group (launched January 2020), and identifying racial disparities and comorbidities of patients with confirmed or suspected COVID-19 infection. In Washington DC, KP has set up free COVID testing at a church in partnership with the Leadership Council on Healthy Communities, and is leveraging the STOP COVID framework for vaccine distribution.

Discussion

Dr. Hughes asked Stacey and Mike if they were able to parse out the role of the plans versus the providers in terms of advancing equity. Mike said the plan is where administration and support is provided at a local level, but that plan is able to leverage all the resources, expertise and capabilities of the corporation. Stacey confirmed it is similar for Kaiser Permanente.

Mila Kofman asked Mike about activities they are doing with their network providers to advance health equity, and which activities have been most successful. Mike responded that UHG offers web-based training and resources, and they have provider advocates that talk with providers and communicate info one-on-one. He noted that UHG's web-based trainings have not been utilized at the rate they would have liked. In the future they plan to conduct listening sessions with provider groups related to providing culturally competent care and addressing health disparities in a meaningful way. Those listening sessions may lend themselves to some other ideas and initiatives. He added that they have not used contracts to incentivize health disparities or cultural competency work.

Mila Kofman asked Stacey if there have identified any barriers to increasing knowledge of health disparities and reducing biased behavior in their physician population. Stacey stated that while there are always early adopters, some physicians take longer to get up to speed. She said that publicizing performance at the physician level may drive action. In addition, patients have the opportunity to change physicians if they are not receiving the care they need. Bonuses are not tied to individual performance around these metrics.

Janice Davis said her clients frequently ask, "How do insurance companies decide what they cover and what they don't cover? Who makes those decisions?" She asked, from a carrier's point of view, how would Stacey and Mike answer that question. Stacey said it has to do with what states require, what employers and employer groups choose, and organizational priorities. Mike said it has everything to do with who is dictating the coverage.

Diane Lewis asked Stacey and Mike to talk about the health outcomes they are seeing in communities of color. Mike said the things that been most helpful in addressing existing health disparities include 1) having a standardized approach to data collection and measurement to identify what disparities exist, and 2) establishing local partnerships. He gave the example of how engaging a local provider to conduct outreach to members increased adolescent well child visits. Stacey said it is difficult to establish a cohort to track health outcomes over time, however they have seen from their interventions a decrease in disparities among certain populations (before the pandemic).

Dr. Hughes asked Mike to expand on UHG's health disparities action plans. Mike said the health disparities action plan is a process for health plans to establish the health measure priorities they want to address. These are normally HEDIS measures. They may address specific measures because 1) it is a contractual obligation with the state, 2) it has been previously identified and there is a performance improvement plan associated with it, and/or 3) there is a community request to focus on particular measures.

Dr. Hughes concluded the meeting with a brief overview of our plans for the next session.

Attendees

Dora Hughes
Helen Mittmann
Diane Lewis
Mila Kofman
Cara James
Purvee Kempf
Debbie Curtis
Stacey Shapiro – Presenter
Mike Currie – Presenter
Patricia Quinn
Paul Speidell
Philip Barlow
Yolette Gray
Yulondra Barlow
Chikarlo Leak
Anneta Arno
Ciana Creighton
Colette Chichester
Daniel Wilson
Janice Davis
Allison Mangiaracino
Margarita Dilone
MaryBeth Senkewicz
Pamela Riley