



Reporting of National and Contract Level Quality Scores by Race and Ethnicity
Madeleine A. Shea, PhD, Office of Minority Health, CMS

Stacey Plizga: Our next speaker will provide you with an overview of quality measures released by the CMS Office of Minority Health and discuss how these data may be used for quality improvement efforts. From the Office of Minority Health, please welcome Madeleine Shea.

[Applause]

Madeleine Shea: Good morning. I am really excited to share with you, for those who don't know, that last month we released for the first time ever HEDIS and CAHPS measures stratified by race and ethnicity to help all of you understand where we have disparities and where we can improve.

Before we go into this, we're going to have a little polling question. We're having a little bit of technical difficulty.

Okay, perfect, so we're going to ask you to choose the responses that apply; you can choose as many as you would like:

I would describe our experience with stratified reporting as: A, We have a good process in place to collect racial and ethnic information from all members; B, This is our first time looking at HEDIS or CAHPS measures by race or ethnicity; C, We provide our practice with dashboards of key quality measures by race and ethnicity; and, D, We have quality improvement processes in place to address health disparities.

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And let's give you a minute to get your responses in.

[Pause for responses]

These are looking pretty solid. So then I'm really excited that I'm here to talk to you today because it looks like almost half of the people who are participating are just looking at their measures for the first time today, stratified by race and ethnicity. So this is a great time to be introduced to your work.

You might be think, well, why are we doing this?

Despite advances in access to care, increased spending, and improvements in quality, racial and ethnic minorities continue to experience worse health outcomes. And so we want to reduce these disparities. And in order to do that, we need to have a systematic, standardized way to collect data, analyze it, and act on it.

We do have authority to do this. The Affordable Care Act mandated improved data collection standards for race, ethnicity, primary language, sex and disability status. Again, it's understanding where we have disparities that will allow us all to address them.

Furthermore, the IMPACT Act of 2014 requires HHS to examine the differential effect of race and ethnicity on Medicare payment policy.

So for this report that we released a couple of weeks ago, you can get on our website; we will be showing you where to get this. There are two data sources. One is the Medicare Consumer Assessment of Healthcare Providers and Systems, called CAHPS, that survey from 2013 and 2014.

And the second data source is the Healthcare Effectiveness Data and Information Set, called HEDIS, which is data collected from Medicare health plans nationwide.

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The CAHPS survey, as probably many of you know, is administered by mail with telephone follow up on a stratified random sample of Medicare beneficiaries. In the 2014 survey, 340,776 beneficiaries responded, with a 41% response rate. This represents all fee-for-service beneficiaries and Medicare Advantage beneficiaries from 531 contracts that have eligible enrollees, at least 600 eligible enrollees.

In the Medicare CAHPS survey, beneficiaries are asked themselves – it's self-report – are you of Hispanic or Latino origin or descent, and what is your race?

And following the U.S. Census approach, the answers to these questions are used to classify respondents as Hispanic, American Indian or Alaska Native, Asian or Pacific Islander, Black, White, Multiracial, or Unknown. And in this analysis, we don't look at multiracial or unknown; we limit it to the designated identified race and ethnicities.

For the HEDIS data, there are clinical care measures in five domains gathered through services, medical records, and administrative data. In 2014, 473 Medicare Advantage contracts, with a total enrollment of 13.2 million beneficiaries, reported at least one HEDIS measure.

Unlike CAHPS data, HEDIS data do not contain the patients' self-reported ethnicity which, of course, makes sense given that it comes from administrative data; and it's not from a survey directly with the beneficiary. So race and ethnicity is imputed using a method that combines information from administrative data, the SIR name, and residential location. And we have really good accuracy for this method. It's something that's used here at CMS. It's 88% accurate for Hispanics, 90% accurate for Whites, 92% for Asian/Pacific Islanders, and 95% for African American.

And for plans that might want to do these analyses themselves, we are hoping to have a model that we can share with you in about a year.

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So CAHPS estimates are case-mix adjusted for age, education, self-rated health and mental health, dual eligibility/low-income subsidy, and proxy respondent status. Scores on HEDIS measures are not adjusted for these characteristics.

So let's dive into what we've found and what you can find on our website in this report. Incidentally, there are reports by plan, as well as a national report. The national report is 2014 data, and the plan level reports are 2013 and 2014.

The first thing we see here is that for the eight CAHPS measures, American Indian/Alaska natives did worse in two of the eight than Whites, is how they reported. For five measures, they reported the same results. And for one, they reported better. And so you can kind of follow this across.

For Asian Pacific Islanders, we see seven measures rated worse than Whites, and one better, none the same. For Blacks, we see three measures rated worse than Whites; five similar. And Hispanics, five measures worse and three similar.

Are you following me – for those that can see?

Okay, so let's look at an example of one of those CAHPS measures: Getting Appointments and Care Quickly. We can see that there really is quite a difference by race/ethnicity in beneficiaries feeling like they're getting appointments and care quickly, with American Indian/Alaska Natives feeling much more positively about this than Asian Pacific Islanders. And then we have the other racial and ethnic groups in between those two.

And then there's another CAHPS measure where we don't see as much variability by race and ethnicity. This would be on doctors who communicate well. We see that actually for this one, the highest rated is

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among Blacks, with 91.6% rating well their experience with doctor communication; and Asian Pacific Islanders, again, feeling less favorably – but the spread is much, much smaller.

Now let's look at some of the HEDIS measures. And this is all to whet your appetite to go and dig in after this meeting. Here we see that for the 27 HEDIS measures, Asian-Pacific Islanders actually fare better than Whites, a little different story than we saw with CAHPS. So 14 of the measures, they're doing better than Whites; 10 the same; and 3 worse. For Blacks versus Whites, we've seen 10 measures worse, 14 the same, and 3 better; and for Hispanics versus Whites -- 9 worse, 15 similar, and 3 better. So let's see what's going on there.

A measure where we see a bigger spread and more evidence of disparities between racial and ethnic groups is blood sugar control, so this is for diabetes hemoglobin A1C control. And we see that the control is much better for Asian-Pacific Islanders than it is for Blacks. And this should be something that I would think you'd want to pay a lot of attention to because there's a lot that falls out from this. So that is one.

But then we have another measure, Appropriate Monitoring of Patients Taking Long-Term Medications, where all the racial and ethnic groups do pretty similarly – just the spread of 94.4% for Hispanics with appropriate monitoring versus 92.6% for Whites.

Okay, so we're ready for another poll before we dive into what we do about all of this. Here I want you to check one response. Check the best response to the following statement: We could use support to address racial and ethnic disparities in HEDIS and CAHPS measures.

Response one: NO, our leadership has not prioritized the reduction of health disparities. Response two: NO, our company does not have the organizational capacity to target health disparities. Three: YES, we want to improve our programs and interventions and need support with a plan;

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or, four, YES, and we are ready to develop programs and interventions or have programs in place now.

Let's see where we are here.

[Pause for responses]

Are we kind of stabilizing? I'll give it another second.

So again, this makes me really happy to be here because we're seeing that the vast majority of those participating today are looking for support to reduce their racial and ethnic disparities in their measures; and that's what the Office of Minority Health is here to help with. And we'll also look at how we can help with those other responses too.

On the website where you will find the national report and your plan-level reports, you will also find a resource called "Building an Organizational Response to Health Disparities." And this is an approach to how you do it that could apply to any one of the measures. So you can get that on our site. It offers resources, guidance for health plans and providers to reduce racial and ethnic disparities in patient experiences and quality measures.

And if you remember our first presentation today, the No. 1 goal was to be about patient experiences and a good experience for beneficiaries. So this is a great way to help you do well there with your Account Managers.

So this has five key areas. The first relates to data collection; the second, data analysis; the third, building a culture of equity; the fourth, quality improvement; and then the fifth is interventions.

This first section that relates to data collection, we even just heard in the last session; if you don't have data, if you haven't collected it, then you're not going to understand it. So this is a really critical first step, and the Guide will walk you through. And actually – sneak preview – next month, we will be release guidance on how to collect racial and ethnic

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demographic information, how to improve your collection of this information. And we'll be getting that information out to you. But this is critical; it's the first step on which we build our understanding.

The second step is if you have the data but you never look at it, it doesn't do you much good either. So it's how to use the data that you have to identify disparities – both the data that we're providing, as well as data that you have -- and establishing a collaborative process to share and analyze what you're seeing.

The third whole area that we would ask you to focus on is building a culture of equity, so how to establish an organizational commitment to addressing disparities. And I did see from some of the responses that this is a challenge for some of you, so we have resources and are here to help with that also. And tips for fostering a culture of equity at all levels of the organization.

The fourth area is quality improvement, so how to address disparities using a quality improvement framework such as the Plan Do Study Act framework or Six Sigma, or whatever of the frameworks that you use in your plans. And then recommendations for infusing disparities focus within your existing quality improvement framework.

This is interventions because ultimately, if you looked at that diabetes measure where there was a big spread, you're going to need interventions to address that. So we offer resources for that as well.

And you can go to our Guide for quick tips on this; and on Friday, we will be releasing a while guide for Targeted Interventions for Colorectal Screening and reducing disparities there; but we'll be rolling them out for other measures as well.

So how would you build an organizational response to health care disparities? We didn't show you the data for the colorectal screening, but I can tell you it's another measure that has a big spread, with racial and

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ethnic minorities doing far worse than Whites here. And how you can implement targeted interventions that lower the costs and maximize your quality improvement efforts, as well as reducing disparities among vulnerable beneficiaries.

So this targeted intervention is an application of the organizational response framework that has a Plan/Do/Study/Act cycle. And if you use a different one, you can plug this in, in a way that makes sense for you.

But it says that first we're going to plan; we're going to analyze what's going on with the data. Then we're going to do and then study and act. I'm going to go to the next slide that gives you some examples here.

For the Planning section, let's say that in your plan you see big racial/ethnic differences in colorectal screening.

First, you're going to want to review the data that we have on our website that you'll have the link for, and really understand what our data is telling you – which is your data. Then you're going to want to look at your own internal plan information and get input from stakeholders on what's going on there, what's the story. This is your understanding so that you can plan what to do about it. And let's just, for sake of an example, say that you're seeing that only 42% of older Black members and 43% of members with limited English proficiency are screened. Hm... that's not very good.

So you want to focus on what's going on there. And you might do a root cause analysis with those you've engaged, your stakeholders – what do people think is going on? And in denied that root cause analysis, people suggest that people don't know they're at personal risk for colorectal cancer. That would be one reason why they wouldn't get screened. And also that you don't have any member materials in the language or in simple English that these populations would really get, that would be motivating to them to get screened.

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So then based on this pre-work that you've done, one thing you could do is pilot this idea that it's about lack of awareness of risk, as well as information that's appropriate for different groups that you serve. Based on that, you're going to pilot what you think would be a good intervention.

So the small scale pilot – your quality improvement team is going to target members in an area that's 30% Black and 15% Spanish or Mandarin-speaking. And you're planning to mail tailored brochures on the risk of colorectal cancer to these members and also to the providers who serve them in these areas where you have big discrepancies in your data.

And then you're planning for the quality improvement team to collect data pre and post mailing out this information to see how it works. What's the before and the after in understanding about risk, attitudes about risk, knowledge, and then, ultimately, getting screened?

Okay, so you do this pilot; and then you are going to look at whether it achieved the results you wanted. What's the result we want? We want to narrow that disparity in the screening rates, so you will see if the posttest shows that Black and members with limited English proficiency – did their perception of risk, knowledge of risk, increase; and ultimately, did they come in for screening?

So this is kind of how you study what happened. And then finally, after analyzing those results, you'll decide on whether you're going to go with a full-scale implementation of the pilot that you did or whether you're going to make some adaptations.

And that's just a little, in a nut shell, the kind of approach that you would have to reducing those disparities. But we are excited to work on this with you. We do have many areas where there are racial and ethnic disparities that have long-term costs to plans because we're kind of talking about prevention things here. Understanding the CAHPS measures that relate to beneficiary experience has a lot to do with the care-seeking and compliance, ability to follow through on health guidance, as well as

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HEDIS measures, quality measures, that relate very much to preventing conditions that can have very expensive outcomes.

That is it in a nutshell. And if you have any questions, please e-mail us at StratifyDataQI@norc.org. And I guess that will be it.

Stacey Plizga: And it's my turn.

Madeleine Shea: Yes.

Stacey Plizga: It's time now, if you have any questions, to step up to the microphone in the center of the room. Please introduce yourself, then tell us where you are from.

Ghita Worcester: Hi, I'm Ghita Worcester from UCare in Minnesota. When you had your survey, there wasn't the opportunity – when you say, do you need help, I think all of us need help in improving the care. But my particular plan has a very large portion of its population that are from the Hmong area – Laos, Vietnam and East Africa. And so when you have the high level of summary information for us, we really need to dig down. And we've been doing this; we follow the Class standards as an organization. This is probably like hours of conversation about what we've already been doing.

But it takes a village, and some of the population don't have a written language. So is there a way to garner feedback in a more proactive manner from plans that might have some best practices for the new immigrant populations? I totally understand social demographic issues and the social determinants. But we're struggling because there are lots of different new immigrant populations that don't fit into a mold of a normal QI process. And we want to do a good job, but there aren't simple roadmaps for us to follow right now.

And the CAHPS that we have been unable to get – and we know from our Asian population, they won't ever give us on a survey a 10 or a 9. They've

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given us that feedback in focus groups. So I think it's so complex that it's not as simple as maybe the picture you were painting is.

Madeleine Shea: There's a lot to culture and to the way people will respond about their experience; you're absolutely right about that. It's not the reason, though, not to look at the data. And I think that's why in our whole organizational response framework that we've set up, engaging stakeholders – which includes beneficiaries – is really critical to understanding the data.

Typically, there will be certain areas geographically – communities – where things will not be working as well. And so it affords you the opportunity to get in there and see – by talking to the providers who serve those communities, in your case the Laotian and Hmong and East Somalian refugees, immigrants, who have come in and would have a very different experience of care.

But as you really refine your model, working with these populations that have a lot of barriers and that you probably don't understand very well, it's a great way to really dive into how you do this work across the board for quality improvement to reduce disparities. And I think it can be a very positive experience for all concerned.

Judi Ross: Hi, there. I'm Judi Ross; I'm with Fresenius Health Plans. We're a new plan in 2016, so we don't have any retrospective data. Can we still access the national data?

Madeleine Shea: Oh, yes, this national report is available for everybody.

Judi Ross: Okay, thank you.

Stacey Plizga: Okay, we will go ahead and take a question that was sent in from our virtual audience. And our first question is: "What do the stratified HEDIS and CAHPS data represent?"

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Madeleine Shea: I described in the beginning of the presentation that the CAHPS measures are based on a survey of members – all the different Medicare beneficiaries – about their experience of care. So it represents what we believe is a representative sample of those that you're serving by race/ethnicity. These measures were picked – it's just a subset of what they respond to in their survey because this subset, we know, has very rigorous, valid, and reliable responses by race/ethnicity. So it represents what beneficiaries themselves are experiencing in their care.

The HEDIS measure is looking at quality measures. This is not from the voices of the beneficiaries, but from these other data sources. So it represents quality differences between different groups. So if you look at control of blood sugar, and you see big differences – as we did – by race/ethnicity, that's a hard quality measure. The plan is not doing as well for Blacks in that case as it is for – I think it was Asian-Pacific Islanders did best in that example. Hopefully that answers that question.

Stacey Plizga: The next question that we have: "Are the data shown at the contract or the plan level?"

Madeleine Shea: They're shown at the contract level.

Stacey Plizga: Okay, the next question: "Are these results included in the MA and Part D Star Ratings Program?"

Madeleine Shea: No, this is another resource for plans to use to continuously drive improvements, but it is not the same thing as your Star's measures.

Stacey Plizga: We do have another question: "Do these results affect MA contract payments?"

Madeleine Shea: No, they do not; but we sure hope that you're paying strict attention to them.

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Stacey Plizga: And the last question that I have here today: "How can MA contracts use the information to improve quality?"

Madeleine Shea: Well, as we like to say in our office, if you don't know about it – if you don't measure it – you can't improve it. So these are your first steps to understanding where there is a difference. And we have spoken to some plans in some early discussions to get their response to their contract-level data. And in a couple of cases, they really weren't aware of these differences. So we believe this is the first step to allow you to do the necessary next steps.

Stacey Plizga: Okay, and if that's all for the questions – I don't see anyone else who has one – I would like to thank Madeleine for the overview of how these data may be used for quality improvement efforts.

Thank you, Madeleine.

Madeleine Shea: Thank you.

[Applause]

Stacey Plizga: Okay, if you would like to evaluate this session, go ahead and you know the drill. Put the "A" in and follow the instructions. And we appreciate your feedback.

[Pause for responses]

Stacey Plizga: There will be a moment to do that. And actually, we will be taking our lunch break next. And we will begin the afternoon session promptly at 12:45 p.m. For our in-person guests, the cafeteria is downstairs. And if you preordered your lunch, please pick it up at the Jazzman Café, which is right outside of the cafeteria.

And for our virtual audience, we look forward to seeing you back here at 12:45 p.m. Enjoy your lunch.