

# Addressing Disparities, Improving Quality and Containing Cost: Culturally Competent Diabetes Management

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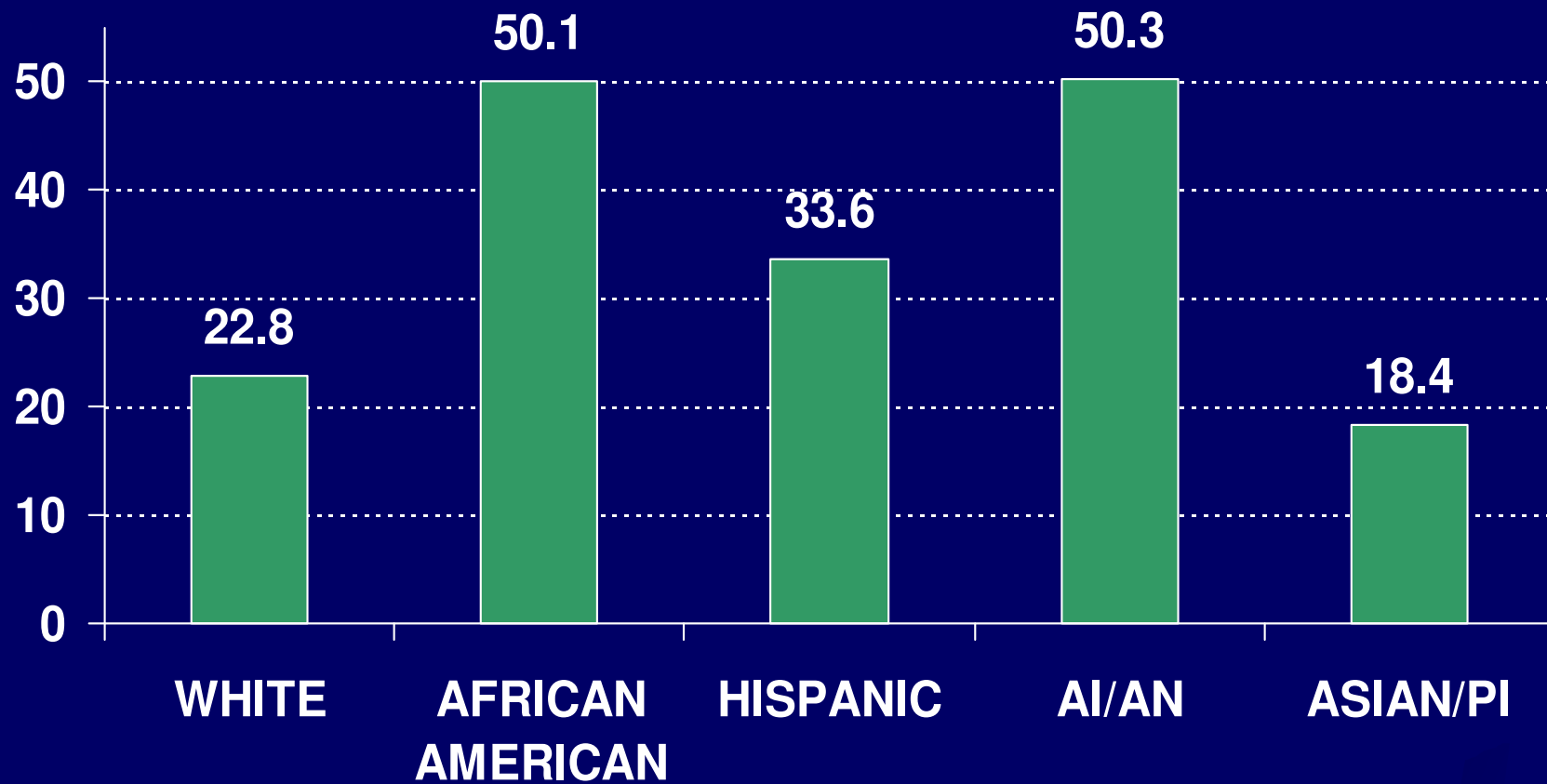


# Outline

- ◆ Disparities in Health and Health Care
- ◆ Key Drivers for Addressing Disparities
- ◆ Improving Quality and Containing Cost: Diabetes

# Diabetes-Related Death Rate, 2004

Deaths per 100,000 population

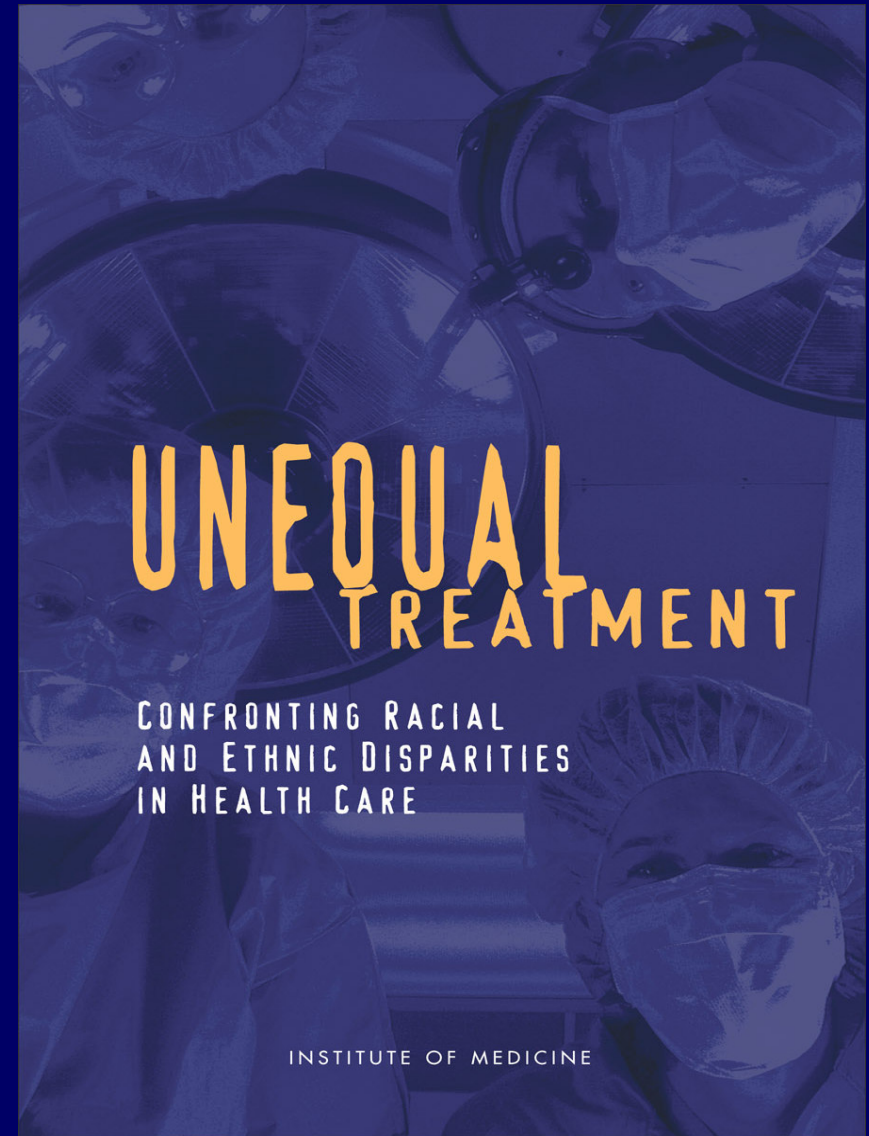


# What causes these Racial/Ethnic Disparities in Health?

- ◆ Social Determinants
- ◆ Access to Care
- ◆ Health Care?

## Disparities in Health Care 2002

Racial/Ethnic disparities consistently found across a wide range of health care settings, disease areas, and clinical services, even when various confounders (SES, insurance) are controlled for.

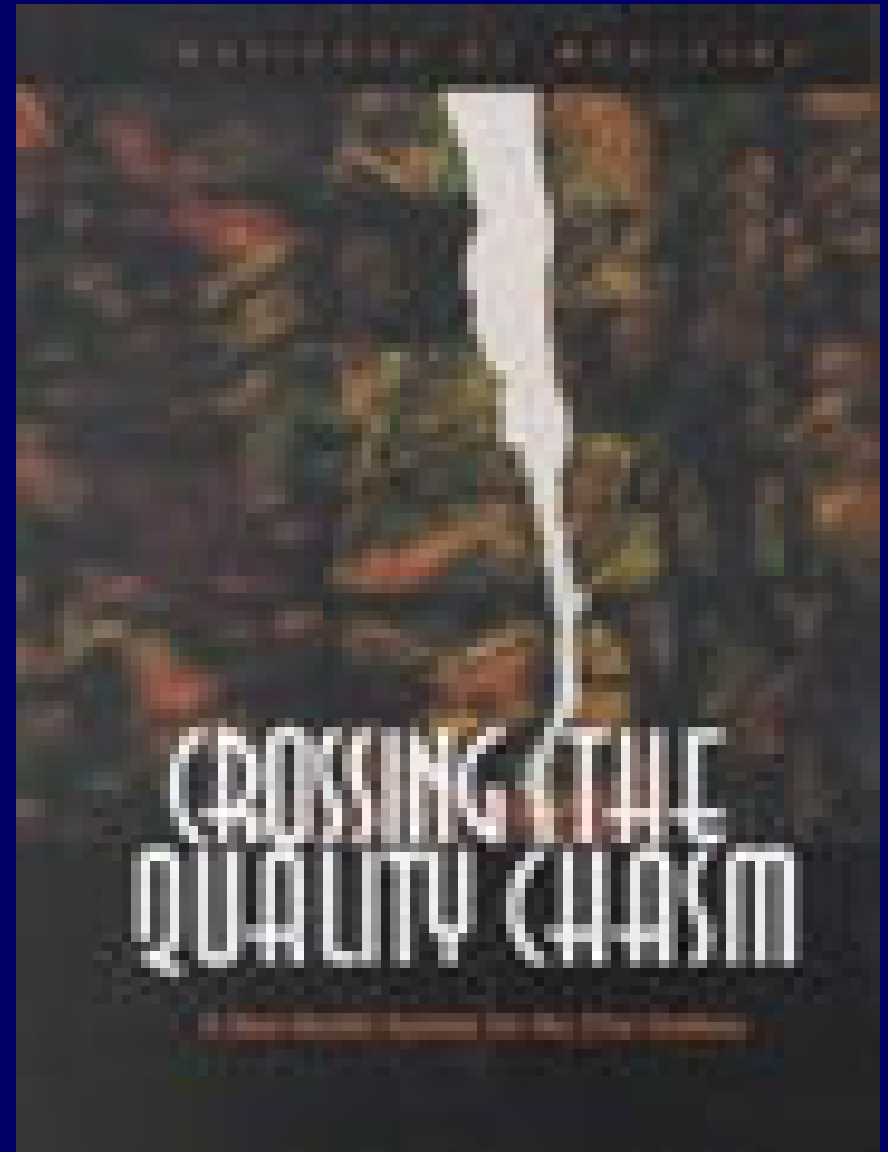


# Key Drivers for Addressing Disparities

- ◆ Quality
- ◆ Cost
- ◆ Accreditation

## Quality Health Care

- ◆ Health care should be
  - Safe
  - Effective
  - Patient-centered
  - Timely
  - Efficient
  - **Equitable**



# The Burden of Disparities: Effects on Cost

Research has shown that disparities, and root causes, lead to:

- ◆ Missed preventive health screenings (CRC)
- ◆ Loss of follow-up and non-adherence (HTN)
- ◆ Less patient involvement in self-management (DM)
- ◆ Misdiagnosis and inappropriate test ordering (ER)
- ◆ Avoidable ER visits, hosp, medical errors and inc LOS

# On the Horizon: Accreditation

## ◆ NCQA

- New efforts in disparities
- Considering measures in the future

## ◆ JCAHO

- New project on culture, health and disparities
- New accreditation standards 2007

# MGH Disparities Committee 2003

## Underlying Principle

- ◆ While data specific to disparities at MGH important, not necessary to begin to take action given IOM Report documented issue nationally

## Charge

- ◆ Coordinate with the Mayor's Efforts
- ◆ **Identify** and **address** disparities in health and health care wherever they may exist at MGH
  - Subcommittees: **Quality, Pt Experience, Education/Awareness**
  - Present plan and results to Board, Executive Council and other hospital leadership regularly

# MGH Committee on Racial/Ethnic Disparities

## Quality

### *Charge*

Stratify QI by r/e, and design improvement activities to address disparities



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» Delivering the Right Care

» Keeping Patients Safe

» Listening to Patients

» Providing Equitable Care

#### Other Reports

» Massachusetts General Hospital  
Joint Commission findings

## Performance Reports

### Delivering the Right Care

Measures of how often MGH adheres to guidelines and provides recommended care for patients with certain conditions and health care needs: heart attack, heart failure, pneumonia, and surgery.

» See full list of measures

### Keeping Patients Safe

Measures of MGH's efforts to reduce potentially avoidable risks for patients.

» See full list of measures

### Listening to Patients

Measures of patients' experiences at the MGH.

» See full list of measures

### Providing Equitable Care

Measures of MGH's success at providing unbiased care across patients of different races, ethnicities, and languages.

Defining the "bucket"

# Disparities Dashboard

## ◆ Executive Summary

### – **Green Light: Areas where care is equitable**

- ◆ Preventive Care: Mammography, Pap smear

- ◆ Patient Satisfaction

- ◆ National Hospital Core Measures (AMI, CHF, CAP)

### – **Orange Light: National disparities, areas to be explored**

- ◆ Mental Health

### – **Red Light: Disparities found, action being taken**

- ◆ Diabetes at community health center

  - Chelsea Diabetes Project

- ◆ Colonoscopy screening rates

  - Chelsea CRC Navigator Program

# Addressing Disparities When Found: Diabetes in Latinos

## The Problem

- ◆ Diabetics at MGH Chelsea doing poorly on several quality indicators - Latinos worse than whites
- ◆ Of 1402 diabetics nearly 1/3 of Latinos and >1/4 of Whites had no HbA1c measured in past 9 months
- ◆ 41% of Latinos and 23% of Whites had HgbA1c > 8

## Key groups involved

- ◆ MGH leadership, DSC, MGH Chelsea, CBO, MGPO, Multicultural Advisory Committee

# Culturally Competent Disease Management: The MGH Chelsea Diabetes Program

A quality improvement / disparities reduction program with 3 primary components:

- Telephone outreach to increase rate of HbA1c testing
- Individual coaching to address patients' needs and concerns regarding diabetes self-management to improve HbA1c
- Group education meeting ADA requirements

\*Also focus on link between mental health, chronic disease management, and prevention

# Diabetes Coaching / Case Management

“ESFT Model” to Promote Adherence via Tailored Education / Intervention

E: Exp Model

S: Soc Risk

F: Fears/Concerns

T: Ther Playback

How do you understand diabetes?

What do you think will help control your condition?

How do you view your treatment?

- Provide education targeted to patient’s EM
- Distribute educational material on diabetes (language/literacy appropriate)

Do you have trouble getting your medications (including affording, getting to pharmacy, etc)?

- Document and Assist

Do you have any specific fears or concerns (side effects, rumors, dose) about your meds?

What other things do you do to treat your diabetes (home remedies, other providers)?

- Education targeted to patient fear/concern
- Verify other meds/providers, rule out contraindications, discuss diet; negotiate

Can you tell me your plan for controlling DM?

- Review with patient

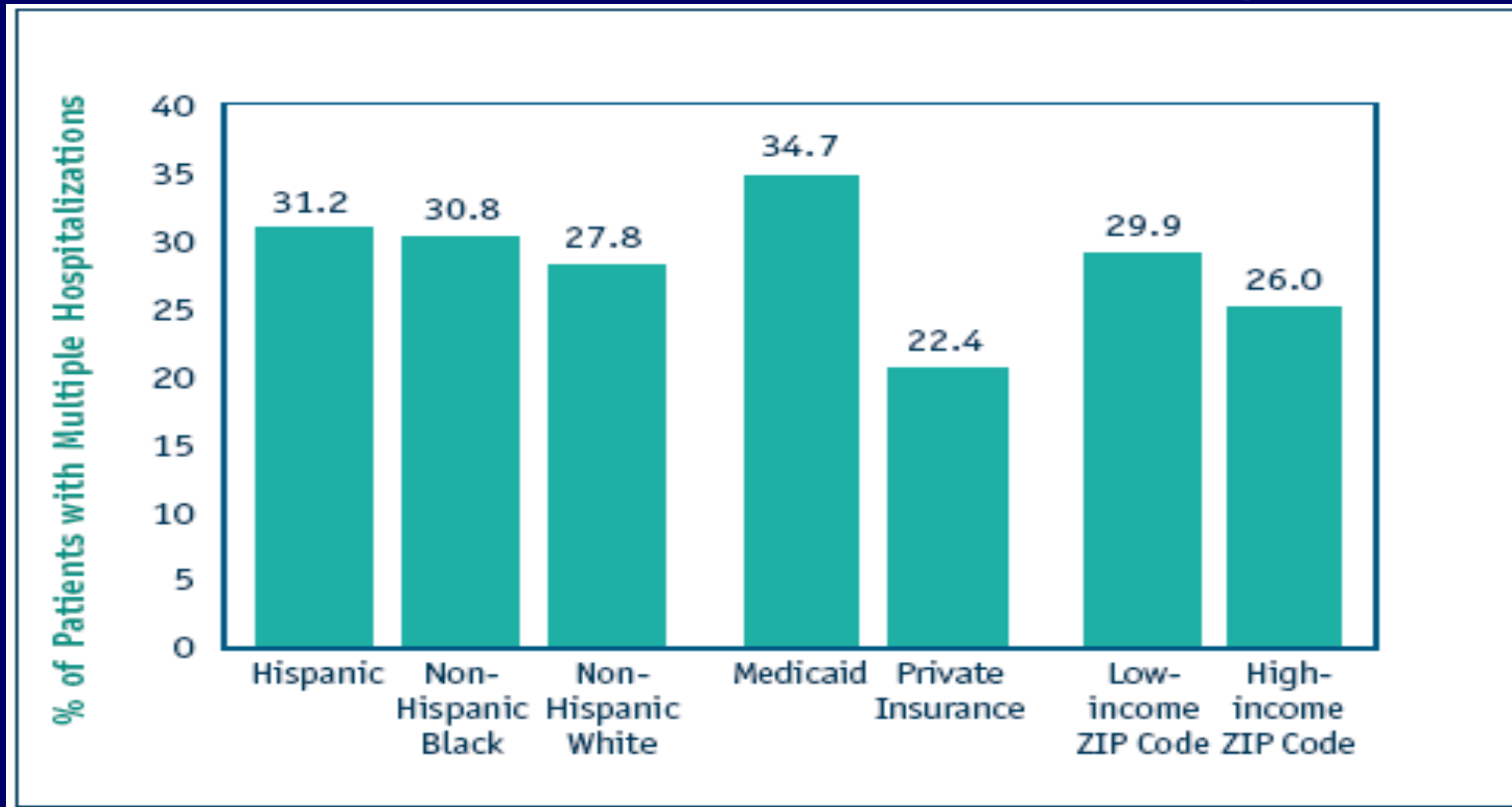
**Formal Feedback to PCP via EMR**

# The MGH Chelsea Diabetes Program Progress to Date

Program began in February 2006

- ◆ 350 Patients enrolled in coaching, 1500 coaching visits
- ◆ 90 Patients have gone through 4 session group education
- ◆ Results: Decrease in HgbA1c close to 1.5 points
  - Better than HRSA Disparities Collaborative Results recently published

# Adult Diabetes Patients with Mult Hosp in a Year



- Diabetic minorities are more likely to experience multiple hospitalizations in a year and have higher costs than their white counterparts
- Although only 30% of diabetes patients who are hosp are re-hosp, they account for more than 1/2 of all diabetes-related hosp costs; considered preventable hosp
- Single hosp: \$8,500; Mult hosp: \$23,100. Recommendation: Enhanced interventions for vulnerable populations and minorities

# The MGH Chelsea Diabetes Program

## ◆ Program Cost:

- Health Coach \$50k/year; .25 FTE RN \$20k/year; .5 FTE Nurse Educator \$30k/year; Clin Oversight .2 FTE MD \$30 = **Approx \$170k/yr (w/fringe)**

## ◆ Projected Cost Savings

- If based on HgbA1c levels can project hospitalization of 25% (44 patients)= \$374,000; if can prevent 60% of these, **cost is \$224,400**

- ◆ **Potential cost savings of \$54,400/yr** (conservative estimate) if these patients have one hospitalization; if 1/3 have multiple hospitalizations, **potential cost savings of \$134,920/yr**

# Summary

- ◆ There is a significant body of evidence that has identified racial/ethnic disparities in health care
- ◆ Hospitals can play a major role in their elimination through quality improvement
  - Quality, Cost, Accreditation are drivers
  - Essential elements include data collection, culturally competent chronic care management
  - Cost savings can be realized, quality improved