Opening & General Session I

In the Face of Health Care Reform: Emerging Roles of Mid-Level Providers to Improve Health Outcomes

Utilizing Interdisciplinary Strategies to Advance from Disparity to Reform
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Jimmy Guidry, MD
Louisiana Department of Health and Hospitals
Fourth Health Disparities Conference
Center for Minority Health and Health Disparities
“Utilizing Interdisciplinary Strategies to Advance from Disparity to Reform”
New Orleans, Louisiana
March 27 – 29, 2011

Department of Health and Hospitals
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Baton Rouge, Louisiana
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✿ Bruce Greenstein, Secretary
✿ Kathy Kliebert, Deputy Secretary
✿ Jerry Phillips, Undersecretary
✿ Jimmy Guidry, State Health Officer, Medical Director
GENERAL SESSION I:  
In the Face of Health Care Reform – Emerging Roles of Mid-Level Providers to Improve Health Outcomes

Jimmy Guidry, M.D.
Health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups.
Factors that Influence Health Disparities

- Higher education is strongly linked to better health status, access, quality and increased income and job opportunities; better housing, food, neighborhoods.
- Rates of unemployment and poverty level
- Discrimination by race and ethnicity
- Other aspects of personal and community health, such as violence, accidents, and crime have also been linked to unemployment and poverty.
Disparities in Health Status

African Americans

• Dying from cancer at a rate of 249.7 per 100,000 population; whites at 197.3 per 100,000; Hispanics at 76.6 population

• HIV/AIDS rates are significantly higher than other racial and ethnic population groups with a 77.6 per 100,000 rate; double that of whites (30.6); triple that of Hispanics (2.7)

• Death rate from prostate cancer is more than double (58.5 per 100,000) the rate for whites (20.7 per 100,000).

• Carry the highest rates of deaths due to stroke with 85.5 per 100,000 compared to whites with 55, Hispanics with 48.1 and Asian/PI suffer from death due to stroke 42.1 per 100,000 population group.
Consequences of Health Disparities:

Poor Birth Outcomes

Louisiana Rankings

Source: LA Vital Statistics
Disparities by Race and Morbidity

Diabetes

Diabetes - Mortality / 100,000 pop

Heart Disease

Heart Disease - Mortality / 100,000 pop

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Why Health Disparities Exist

Lack of

- Insurance coverage
- Regular source of health care
- Structural barriers
- Linguistic barriers
- Health literacy
- Diversity in the healthcare workforce
Causes of health disparities are numerous and cannot be dealt with in a “one size fits all framework.”
So, what’s Louisiana doing about health disparities?
DHH Structure’s Working Together

Bureau of Minority Health Access

• Facilitates collection, analysis, dissemination and access to information concerning minority health issues and to address and eliminate health disparities for the underserved, under-represented populations in Louisiana by using multi-cultural and culturally-competent approaches to enhance the ways in which health services are designed and delivered;

• Building the capacity of national, state, and local government to develop, implement, monitor, and evaluate high quality cultural competence strategies for all domains of public health, including policy, funding, and programs.

Bureau of Primary Care and Rural Health

• Provide a central information and referral source.

• Increase public awareness by publicizing minority health issues through the media.

• Develop minority health initiatives including cultural competency standards and multilingual communications.
Improving Birth Outcomes

Market Analysis

- LA Ranks 49th for infant mortality
- Health disparities define and shape these poor rankings due to extremely elevated poor outcomes in the state’s African-American population.
- Almost 70% of the state’s births are financed by Medicaid (highest % in the nation).
- Hospitals are not required to report on many of the metrics needed to reliably measure costs and quality.
- Delayed reporting of statistics on birth outcomes.
- Statewide data sharing needs to be improved.
- State ranks 50th for breastfeeding rates and has some of the highest cesarean sections in the nation
Improving Birth Outcomes

- DHH Birth Outcomes Project

  - Focused on developing a plan for increased coordination of resources and targeted investments that can make positive impacts on birth outcome measures such as
    - Preterm birth
    - Low-birth weight
    - Hospital-based maternity care
Improving Birth Outcomes

- DHH Birth Outcomes Project
  - Targets 5 major areas for improvement
    - Care coordination
    - Measurement of Birth Outcomes
    - Patient Safety and Quality
    - Health Disparities
    - Behavioral Health
  - Recommendations by June 2011
  - Implementation by July 2011
Health Disparities Collaborative – Louisiana State Cluster

- Three clinic-based teams from across the state working collaboratively over a 16-month period to learn and adopt principles of the Planned Care Model.

- Focus on providing disease management treatment and care to patients diagnosed with diabetes and/or cardiovascular disease and encouraging tobacco cessation attempts among patients that use tobacco products.

- Clinics received technical assistance and training from the Louisiana Department of Health and Hospitals (DHH) - Chronic Disease Prevention and Control Unit and the Louisiana Primary Care Association (LPCA)
LA HDC Multidisciplinary Team Approach

- Encouraged multidisciplinary teams and collaborative working relationships among the following:
  - Patient
  - Primary Care Physician
  - Nursing Staff
  - Medical Assistants
  - Diabetes Specialty Nurse (Certified Diabetes Educator)
  - Pharmacist
  - Podiatrist
  - Smoking Cessation Counselor (Louisiana Tobacco Quit Line)
  - IT Coordinator (Diabetes Registry)
Health Disparities Collaborative – LA State Cluster

**Project Elements**

- Pre- and post-assessment (Assessing Chronic Illness Care Survey)
- Chronic disease registry
- DHH & HDC-LA contracts
- HDC-LA working group
- Quarterly learning sessions
- Monthly conference calls
- Quarterly & monthly reports
- Onsite technical assistance
- Connection to resources

**HDC-LA Manual Cover**
LA HDC Clinical Health Outcomes

Data from each clinic’s chronic disease registry showed:

- Increase in number of patients receiving recommended tests
- Increase in number of patients screened for tobacco use and exposure to environmental tobacco smoke
- Increase in patient referrals to tobacco cessation services
- Overall improvement in blood pressure control
- Slight improvement in average Hemoglobin A1C rates
Health IT and Chronic Disease Management

Blue Cross and Blue Shield of Louisiana

Quality Blue Initiative

- Identify and reward physicians and healthcare providers who deliver high-value quality care that meets national standards of excellence
- Financial incentives to doctors who achieve certified recognition of quality in diabetes care and cardiac care, as well as smart office practices in primary care that produce better outcomes for patients

Health Information Technology Initiatives

Louisiana Health Care Quality Forum (LHCQF)

Incentives to adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology

**Louisiana Medicare EHR Incentive Program**

- Eligible professionals can receive a maximum incentive payment of $44,000 over five years

**Louisiana Medicaid EHR Incentive Program**

- Eligible professionals can receive a maximum incentive payment of $63,750 over six years

Discussion/Questions

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In the Face of Health Care Reform:
Emerging Roles of the Mid-Level Providers to Improve Health Outcomes

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Florida Memorial University

Utilizing Interdisciplinary Strategies to Advance from Disparity to Reform
Two Major Pieces of Health Reform Legislation

- **July 30, 1965** - President Lyndon Johnson signs into Law the Medicaid and Medicare Program as part of his “Great Society”

- **March 23, 2010** - President Barack Obama signs into law the Patient Protection and Affordable Care Act (P.L. 111-148)
Tremendous Progress in the 20th Century in the U.S. on Years Lived

*Death registration area only. The death registration area increased from 10 states and the District of Columbia in 1900 to the coterminous United States in 1933.

1. The Problem: Is it Cost or Access?

- **ACCESS**
- **AFFORDABILITY (COST)**
- **ACCOUNTABILITY (QUALITY)**

**HEALTH CARE SPENDING: 2008:**
- $2.4 trillion
- $7,421 per person per year
- 16.3% of GDP

The Problem: Access

Health Insurance Coverage in the U.S., 2008

Uninsured 15%

Employer-Sponsored Insurance 52%

Medicaid/Other Public 13%

Medicare 14%

Private Non-Group 5%

Total = 300.5 million

46 million

NOTE: Includes those over age 65. Medicaid/Other Public includes Medicaid, SCHIP, other state programs, and military-related coverage. Those enrolled in both Medicare and Medicaid (1.9% of total population) are shown as Medicare beneficiaries.

SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urbam Institute analysis of March 2009 CPS
Uninsured Nonelderly vs. All Nonelderly, by Family Poverty Level, 2008

**Uninsured**

- Under 100%
  - 38%
- 100% - 199%
  - 29%
- 200% - 299%
  - 16%
- 300% +
  - 17%

**All Nonelderly**

- Uninsured: 45.7 Million
- All Nonelderly: 262.8 Million

*NOTES:* Data may not total 100% due to rounding. The Federal Poverty Level for a family of four in 2008 was $22,025 (according to the U.S. Census Bureau’s poverty threshold). Family size and total family income are grouped by insurance eligibility. SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of 2009 ASEC Supplement to the CPS.
Uninsured Rates Among Nonelderly by State, 2007-2008

National Average = 17%

The Problem: Cost

Per Capita Health Care Spending in Various Countries in 2006, According to the Country's Relative Wealth.
The data points represent actual spending, whereas the curve represents the spending expected on the basis of the per capita gross domestic product (GDP). PPP denotes purchasing power parity. Data are from the Organization for Economic Cooperation and Development and the McKinsey Global Institute.

Average Annual Premiums for Single and Family Coverage, 1999-2009


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* Estimate is statistically different from estimate for the previous year shown (p<.05).
Percentage of All Firms Offering Health Benefits, 1999-2009*

*Tests found no statistical differences from estimate for the previous year shown (p<.05).

Note: Estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

The Problem: Cost - Medicare

Projected Medicare Outlays, 2008-2018

Total outlays in billions:

$1,000 $800 $600 $400 $200 $0

$454 $486 $514 $567 $568 $636 $681 $729 $814 $850 $887

Share of:

16% 16% 16% 17% 17% 18% 18% 18% 19% 20% 20% 20%

Federal Budget

Gross Domestic Product

3% 3% 3% 3% 3% 3% 4% 4% 4% 4% 4% 4%

NOTE: Numbers have been rounded to nearest whole number.


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## Financing: Private or Public?

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<th>Country</th>
<th>Private</th>
<th>Public</th>
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<tbody>
<tr>
<td>U.S.A.</td>
<td>54%</td>
<td>46%</td>
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<tr>
<td>Canada</td>
<td>30%</td>
<td>70%</td>
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<tr>
<td>Italy</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>U.K.</td>
<td>12%</td>
<td>88%</td>
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There is NO pure public or single-payer system at least in the major industrialized countries.
Is Reform Already Occurring?

**State level initiatives (a few examples)**
- Hawaii – Health Quest (1994)
- Vermont – Catamount Health (2005)
- Illinois – All Kids (2005)
- Washington (2007)
- Florida (Cover Florida) – modest start this Jan. 1st, 2009

**Federal level initiatives**
- Veterans Administration
- Medicaid
- Medicare
- SCHIP (State Children’s Health Insurance Program)
Massachusetts Health Care Reform

- Unique history of Massachusetts
  - Individual mandate
  - Employer mandate
  - Commonwealth Care Health Insurance
    - subsidized for people < 300% FPL
  - Commonwealth Connector (Health Insurance Exchange)
    - Six companies currently
  - MassHealth (Medicaid) Expansion
    - Overall, has added 430,000 people to insured rolls (since began in 2006)
  - Challenges:
    - Cost (additional taxes $1.2 billion this year, even with 10% increase in premiums to patients)
    - Access (eg. not enough doctors)
  - Question has already arisen: Is this sustainable (financially)?
  - Will this system be transferable to other states/the nation?
Key Provisions of the Patient Protection and Affordable Care Act

Coverage and Cost Estimates

- Congressional Budget Office (CBO) estimates the legislation will reduce the number of uninsured by 32 million in 2019.

- Net cost of $938 billion over 10 years.

- CBO estimates that by 2019, 24 million people will obtain coverage in newly created state health insurance exchanges.

- Reduce federal deficit by $124 billion over 10 years.
Key Provisions of the Patient Protection and Affordable Care Act

**Individual Mandate**

- All individuals will be required to have health insurance beginning 2014, with some exceptions.
- Penalty for not having health insurance the greater of $695 per person (up to a maximum of $2,085 per family), or 2.5% of household income.
Expansion Of Public Programs

- Medicaid will be expanded to all individuals under age 65 with incomes up to 133% of the federal poverty level. ($14,404/individual and $29,327/family of four)

- Create State Health Exchanges for people without employer sponsored insurances.

- Medicaid and Children’s Health Insurance Program (CHIP) for children will continue at their current eligibility levels until 2019.

- 100% of Medicaid Expenses for those becoming eligible between 2014-2016 will be federal. 95% for 2017; 94% for 2018 and 93% for 2019.
American Health Benefit Exchanges

- States will create American Health Benefit Exchanges
- Access to Exchanges will be limited to U.S. citizens and legal immigrants.
- Premium subsidies will be provided to families with incomes between 100-400%.
- Cost Sharing subsidies will be available to limit out of pocket spending.
Changes To Private Insurance

- Insurers cannot deny coverage due to an existing condition.
- Health Insurers will be prohibited from imposing lifetime limits on coverage.
- Young adults will be allowed to remain on their parents insurance to age 26.
- Existing coverages will not change.
Employer Requirements

- No employer mandate but employers with 50 or more employees will be assessed $2000 per full-time employed if they do not offer coverage.

- Exchange payments required of employers in some conditions

- Large employers required to automatically enroll employees even if they opt out.
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Thank you for your participation!