

Proceedings: Data Driven Action: Pathways to Health Equity

Disparities National Coordinating Center

Virtual Conference

October 1, 2013

Author: Disparities National Coordinating Center, Delmarva Foundation of Medical Care, Inc.

Editors: Izione Silva, Ph.D. and Madeleine Shea, Ph.D., Disparities National Coordinating Center (DNCC), Delmarva Foundation for Medical Care (DFMC)

Acknowledgements

Speakers:

Stephen Thomas, Ph.D., University of Maryland Center for Health Equity, Darrell Hudson, Ph.D. from the Brown School of Social Work at the University of Washington, and Jie Chen, Ph.D., University of Maryland, School of Public Health

Panelists:

David Sohmer, Care Transitions Aim Lead, Mountain Pacific Quality Health-Alaska; Mark Marabella, Prevention Project Manager, Mountain-Pacific Quality Health-Hawaii; Shanti Wilson, M.B.A., PMP, HIT former Director, Health Services Advisory Group of California; Patricia Merryweather, Executive Director, Michael Townsend, Ed. D., Quality Improvement Facilitator and Vadie Reese, Senior Quality Improvement Facilitator, Telligen of Illinois; Jennifer Conner, Ph.D., Director, Arkansas Foundation for Medical Care; Sarah Irsik-Good, M.H.A., Director of Quality Improvement, Kansas Foundation for Medical Care, Inc.; Margy Wienbar, M.S., Director of Operations and Elayne Villa, Project Coordinator, Health Insight New Mexico; Virginia Brooks, M.H.A., CPHQ, Director of Prevention, Sharon Alloway, M.H.A. Area Manager, Prevention and Geri Stahl, B.S. Area Manager, Prevention, Virginia Health Quality Center

Moderators/Commentators:

Community Engagement Panel moderated by: Heidi Turpin, B.S., MAHS, Project Resource Consultant, and Brenda V. Ortiz, Program Manager – Health Disparities, TMF Health Quality Institute of Texas. Data Panel moderated by: Shanta Whitaker, Ph.D., M.P.H., Senior Disparities Analyst, Disparities National Coordinating Center, Delmarva Foundation for Medical Care, Inc.

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October 1, 2013 12:00-4:30pm EST

Summary

The Disparities National Coordinating Center (DNCC) in partnership with University of Maryland Center for Health Equity (M-CHE) held a virtual conference on Tuesday October 1, 2013. An estimated 210 participants joined national and local disparities experts and Quality Improvement Organizations (QIOs) to learn ways to better engage communities and use data to achieve greater health equity among racial and ethnic minorities.

Background on the DNCC and QIOs: The Quality Improvement organization (QIO) program is a key mechanism by which the Centers for Medicare & Medicaid (CMS) improves the quality of care for Medicare's more than 50 million beneficiaries, including the growing proportion of this population who are racial and ethnic minorities or from underserved populations. CMS contracts with 53 organizations representing every state, as well as the US Virgin Islands, Puerto Rico, and the District of Columbia. By law, the mission of the QIO Program is to improve the effectiveness, efficiency, economy and quality of services delivered to Medicare beneficiaries. CMS awarded Delmarva Foundation for Medical Care of Maryland as the Disparities National Coordinating Center (DNCC) in September 2012. The role of the DNCC is to support all QIOs efforts to reduce health disparities among underserved Medicare populations. This national Virtual Conference is one of many trainings and conferences held monthly for all of the 53 QIOs.

Presenters/Moderators: Madeleine A. Shea, Ph.D., Director of the Disparities National Coordinating Center, moderated the conference. Speakers included Jean Moody Williams, RN, MPP, Director of Quality Improvement Group at Centers for Medicaid and Medicare Services (CMS); Stephen Thomas, Ph.D. from M-CHE, Darrell Hudson, Ph.D. from the Brown School of Social Work at the University of Washington, and Jie Chen, Ph.D., from the University of Maryland, School of Public Health. Two QIO panels summarized their health disparities efforts and perspectives on Community Engagement, and Data and Health Equity. The Community Engagement panel included: Mark Marabella (Hawaii); David Sohmer (Alaska); Shanti Wilson (California); Patricia Merryweather, Michael Townsend, and Vadie Reese (Illinois). The Data and Health Equity panel included: Jennifer Conner (Arkansas), Sarah Irsik-Good (Kansas); Margy Wienbar (New Mexico); Virginia Brooks, Sharon Alloway (Virginia). Participants had an opportunity to ask questions at the end of each presentation.

Introductory Remarks: Jean Moody Williams, RN, MPP, CMS

Ms. Williams provided an overview of the Medicare health disparities problem. She stated that Medicare beneficiaries comprise 15% of the U.S. population and she described beneficiaries in terms of demographics, chronic conditions, and level of coverage. She stated that beneficiaries of color are less

likely to receive preventive care, less likely to have a primary care office visit, and more likely to use emergency services. While recognizing the work of the QIOs to reduce disparities, she also discussed provisions in the Affordable Care Act (ACA) to increase access to preventive services. She stressed the importance of addressing health disparities especially as the nation becomes more and more diverse.

Key Note #1: Stephen Thomas, Ph.D., University of Maryland

Dr. Stephen Thomas: “Less Talk More Action: Accelerating Innovative Strategies to Engage Racial and Ethnic Minority Communities in Health Care”

Dr. Thomas challenged the health disparities community to use what it knows now since it cannot afford to have a large segment of the community “locked in a cycle of chronic disease.” He stated that community engagement is the core driver of the work of the Maryland Center for Health Equity. Equally important is the gathering of data, especially on race and ethnicity given the changes in our nation’s demographics. He reviewed historical markers for progress such as the 150th anniversary of the Emancipation Proclamation and the 50th anniversary of the March on Washington. He mused that perhaps the ACA will also be seen in the future as a transformative step in the elimination of disparities.

He reminded the audience that working with the community requires recognition that communities’ historical memories of past abuses can lead to reluctance to participate, not only in research, but also in healthcare. He, subsequently, offered a framework to move the work on disparities forward.

He shared four “generations” or levels of disparities research. The first is to document the existence of health disparities. The second is to explain the reasons for disparities. The third is to provide solutions to eliminate disparities involving randomized clinical trials and published research. The fourth is to be action-oriented and use culturally-tailored interventions. He stressed the need to build on assets at all levels, embed the work in the community values, and focus on health equity since racism and structural determinants keep people from getting well.

Dr. Thomas challenged the audience to work towards “cultural confidence,” as opposed to “cultural competence.” He defined cultural confidence as a process of assisting providers to engage in a lifelong process of self-reflection about their own personal biases and prejudices. He urged attendees to participate in and share information on different types of training available at the Center for Health Equity. He highlighted successful projects such as the Healthy Black Families Project and Health Advocates in Research (HAIR).

He concluded by challenging the audience to no longer be victims of inaction and to view this work as a moral responsibility to move forward.

Community Engagement : QIO Perspective Panel

Four Quality Improvement Organizations (QIOs) shared the various ways they engaged the community to address health disparities. QIOs from Alaska, California, Hawaii, and Illinois described a community need that they backed up with data, ways they went about building partnerships to address that need, a description of the project, results, and recommendations. Brenda Ortiz and Heidi Turnip, TMF Health Quality Institute of Texas, made final remarks. Below is a summary each presentation.

- Alaska -- “Medical Respite Care for the Homeless,” David Sohmer, Care Transitions Aim Lead, Mountain Pacific Quality Health.

Unlike most who are hospitalized, the homeless in Anchorage did not have a safe and clean environment to recuperate from a hospital stay. They were well enough to be discharged but not well enough to be back on the streets. Medical Respite Care for the Homeless addresses that need and provides integrated services to the homeless and mentally ill. Services are geared towards the whole person and run the gamut from food and shelter to case management. Even though clients stay an average of 35 days, medical respite has proven to be low in cost yet high in quality.

The first program began in Washington, DC in 1985, and at present there are 62 programs nationwide. Anchorage’s program resulted from efforts to address the needs of a small group of vulnerable Medicare beneficiaries who were: homeless, mentally ill, frequent users of the Emergency Department, and experienced high rates of hospital readmissions. During a Learning and Action Network session at a Patient Safety Conference in October 2012, a telephone participant described a program in Juno (Alaska) on respite care. The Anchorage group visited the Juno site and then established a Steering Group made of public, private, academic, and medical groups to replicate the program. The resulting program, The Anchorage Care Transition Network, is saving money, freeing hospital beds and improving quality of care.

- California - “Community Building to Close Health Disparities,” Shanti Wilson, M.B.A., former Director, Health Services Advisory Group of California (HSAG-CA)

To reduce cardiovascular disparities among African Americans, HSAG-CA sought to engage the community by working with trusted local community groups and social hubs. They also solicited assistance from community leaders to leverage their experience and wisdom. For its program on hypertension, HSAG-CA implemented two interventions at two safe and easily-accessible locations.

- Fruitridge Community Center - HSAG-CA partnered with the American Heart Association and worked with the Director of a local community center. They weaved the blood pressure screening program into the activities of the community center, making sure not to interrupt important regular activities such as Bingo. This program also included Q&A sessions with a provider from the American Heart Association. Within a two-month period the percentage of those with uncontrolled blood pressure dropped from 73% to 47%.

- Barber Shop – HSAG-CA partnered with the Black Nurses Association and “100 Strong” to screen blood pressure among 39 African Americans at a barber shop. Of those screened 31% had normal blood pressure while 61% had uncontrolled levels. The program referred those with abnormal blood pressures to medical care and provided subsequent follow-up.

This program demonstrated the value of creating partnerships with trusted organizations, selecting easily accessible locations, and scheduling activities at a time that is convenient for participants. Such steps often lead to greater acceptance, participation, and better health outcomes for participants of evidence-based intervention programs.

- Hawaii – “Addressing Disparity with Learning and Action (LAN),” Mark Marabella, Prevention Project Manager , Mountain-Pacific Quality Health

This presentation stressed the need to work from the bottom up in order to address community needs. In Waimanalo, close to 70% of the population is of Hawaiian or Pacific Island descent. This population has high rates of obesity and diabetes. They also have the highest coronary heart disease mortality rate in Hawaii. Of those surveyed, about a third reported no time for physical activity. Waimanalo residents live in homestead land in extended families comprising three to four generations. They view doctors as authority figures who are not to be questioned and whose time is not to be wasted. They offered a number of ways that the healthcare system can be improved to enhance community engagement and communication. For example, they shared that many healthcare messages are not understood by the community. Yet, community members do understand the value and necessity of prevention and the need for training on disease self-management. This viewpoint contradicted generally held assumptions that beneficiaries were indifferent and that their lack of participation represented a barrier.

Mountain-Pacific Quality Health partnered with a Federally Qualified Health Center (FQHC) community clinic and created a beneficiary learning action network (LAN) to design the Therapeutic Lifestyle Change Program. They used the rapid cycle process where all aspects of the intervention – educational content as well presentation and delivery of material -- were tested using a beneficiary audience. To achieve the objectives of the program, a 12-week LAN, Play4Prevention, was developed using information from Million Hearts and the American Heart Association. The program also addressed behavior change by examining ways to change habits and included the sharing of information from various healthcare providers. The transformative power of this program and other related QIO efforts changed how the beneficiaries were viewed – from part of the problem to part of the solution.

- Illinois – “Community Engagement: Quality Improvement Organization Perspective Panel,”) Patricia Merryweather, Executive Director; Michael Townsend, Quality Improvement Facilitator and Vadie Reese, Senior Quality Improvement Facilitator -Telligen of Illinois

Telligen was “startled” by its analysis of the 2012 data on care transitions from the NCC Report.

Compared to national rates, Illinois admissions and readmissions rates were high. Among blacks and Hispanics, those rates were even higher. Telligen used data to drive and focus their initiatives. They examined geographic variation, financial resources, literacy, health literacy, race, ethnicity, incidence of violence, and incidence of cardiac disease. Based on this analysis, they chose to engage community and faith-based organizations in two African-American and Hispanic neighborhoods with the highest incidence of cardiac disease in two programs. First, they expanded flu immunizations in nursing homes with low rates of immunization. They organized presentations by high performing nursing homes to low performing nursing home administrators, and education of residents and families on the benefits of immunization. Second, they implemented the First Ladies Initiatives (wives of church pastors). In September 2012, over 40 churches participated in the First Ladies Health Initiative where health screenings were provided on a Sunday during and after church services to increase early detection of chronic disease.

Telligen has been awarded a new Special Innovation Project to reduce hospital admissions and readmissions that will focus on increasing preventive services for African Americans and Hispanics. It will identify and work with community and faith-based organizations to target senior communities. It will identify barriers and ways to overcome them through engagement with seniors from an advisory group, develop culturally sensitive materials and use radio health talk shows to reach beneficiaries.

- Panel Commentator: Texas - Brenda Ortiz and Heidi Turpin, TMF Health Quality Institute

Ms. Ortiz and Ms. Turpin described their work to engage African Americans with diabetes in diabetes self-management. Many of the issues brought up by the other QIOs resonated with Texas. They agreed that to be successful, disparities projects have to develop partnerships which garner support from targeted communities. They asked the QIOs critical questions about their community engagement methods and future initiatives. Below are two questions they posed to the panel.

1. How can we be better at engaging from the community we are trying to serve? How can we replicate some of these strategies on a larger scale?
 - Illinois: One of the first things one has to do is to build trust. To build trust you have to know the community and faith based organizations. It is important that your work is locally- based and can spread regionally. You have to be out there in the community. The other thing is most community organizations have involvement with other organizations, so tapping into local organizations can help spread.
 - Dr. Thomas: Building trust requires some real skills and for some people it will require new skills. We provide free trainings at www.buildingtrustumd.org.
 - Texas: I want to add that we have found that we have to go more grassroots to build trust. Rather than focus just on faith based organizations, we have found independent educators that want to work with us.
2. Do you have experience incorporating local celebrations in your programs?
 - Dr. Thomas: One of the things we find is that you have to be consistent because many of the communities have felt abandoned. They have opened up to outside interests and

then been left behind. Community engagement needs to be incorporated into the DNA of organizations. Using annual celebrations can be effective.

- California: One of the first events we did with the American Heart Association was a Black History Month event that discussed the history of the African American diet and how traditional African American meals can be changed into healthier meals.

Key Note #2: Darrell Hudson, Ph.D., University of Washington

Dr. Darrell Hudson : “Why Race and Ethnicity Data Matter in Understanding Health Disparities”

Dr. Hudson cited health disparities as the Civil Rights issue of the 21st Century and provided definitions from Healthy People 2020 and the Institutes of Medicine (IOM). He highlighted the trajectory of AIDS among the four racial and ethnic groups. From the mid- 1980s to 2008, the rate of whites infected was higher than that of African-American, yet in 2008 the inverse was true. The remainder of his talk focused on two questions: What explains disparities and how data can drive action.

- What explains disparities? - Disparities can be explained mainly by social determinants, a complex set of personal and social factors that affect one’s health. Disparities relate to race, socioeconomic status and context as well where one is born, lives, works, play, and age. Dr. Hudson proceeded to explain each of the contributing factors and stated that social determinants are not well understood and yet they have the most potential to explain and reduce disparate health outcomes.
- How data can drive action? – Dr. Hudson discussed how Congress identified reductions in hospital readmissions as an approach to reduce Medicare spending and stated that many beneficiaries at highest risk of readmissions have Type II Diabetes along with another diagnosis. He proceeded to show how data can be used to get a picture of a community by zip codes. The 2009 map of St. Louis, MO shows areas with the greatest number of overall hospitalizations and the greatest number of diabetic Medicare patient hospitalizations.

Dr. Hudson ended his presentation with examples of data-driven action in St. Louis, including a program to increase diabetes self-management among seniors living in high-risk zip codes. In addition, he provided references to national big data sets such as the Agency for Healthcare Research and Quality’s Medical Expenditure Survey, National Health Interviews, Behavior Risk Factor Surveillance Survey (BRFSS), and the Dartmouth Atlas of Healthcare.

Data and Health Equity: QIO Perspective Panel

QIOs from Arkansas, New Mexico, Kansas, and Virginia discussed how they have been collecting race, ethnicity and language data, and how they have stratified those data to identify populations at risk, gaps in services, and improve care quality.

- Arkansas – “Improve Quality of Care by Collecting Race, Ethnicity and Language Data”, Dr. Jennifer Conner, Director, Arkansas Foundation for Medical Care

Dr. Conner discussed the importance of collecting race, ethnicity, and language data. She stated that according to the Institute of Medicine Report: Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, “ethnic minorities receive lower quality healthcare, and experience higher rates of disease, disability and premature death.” It is, therefore, important to collect racial, ethnic and language data to inform quality improvement activities and preventive health care services, interpreter services, and the translation of written patient information. Data can also offer insights into population health trends. Dr. Conner discussed the legal justification for collecting race, ethnicity, and language data and reviewed ways to decrease barriers to collection. Some approaches include making sure practice management systems set up fields to collect this information, and that staff is trained on how to appropriately ask for the information.

The Arkansas Foundation for Health Care developed a tool for data collection, as part of a previous QIO program. It is now working to stratify data on at-risk populations with diabetes and to provide assistance and training to the Arkansas Chronic Illness Collaborative. They are pulling reports from electronic health records (EHR) and checking for missing demographic information. They have encountered some challenges which include: overcoming personal reservations to ask for personal information; developing a standardized process to collect and analyze data within the clinics; and managing issues related to small numbers in particular racial and ethnic groups in some rural clinics. They have been successful in their staff trainings focused on the need for collection and analysis of data.

Dr. Conner concluded by showing two race-stratified graphs from a Million Hearts partner, a rural clinic that sees 10-15 patients per day. She stressed the importance for clinics to collect demographic data to capture this information to run reports. Electronic health record (EHR) vendors also need to be engaged on provider level needs to stratify data by race and ethnicity.

- Kansas – “Kansas Disparity Journey, Sarah Irsik-Good, M.H.A., Kansas Foundation for Medical Care, Inc.

Ms. Irsik-Good acknowledged that a year ago as far as data collection was concerned, Kansas Foundation was “just doing enough ... barely” to meet contractual obligations. They participated in DNCC webinars and other activities, but once they started receiving data reports from the DNCC, they realized that they had to do more. DNCC data allowed them to see specific disparities of concern, specifically cardiac health in Southeast Kansas. The needs appeared to relate to a lack of access to primary care in this rural corner of Kansas.

To address this disparity, Kansas participated in the Patient Family Engagement Campaign (PFEC) to address primary care access in Southeast Kansas. They hired staff with communications and outreach expertise and created a Disparities Team. This team provided cross-theme attention to disparities in the state and used lessons learned across contractual obligations for the 2012 fiscal year. The Disparities

Team acts as the data integrator and presents data at project team meetings. It also brings awareness, education and technical assistance to providers and beneficiaries alike. Conference participants were encouraged to increase awareness, make disparities a priority and work through multidisciplinary teams.

- New Mexico – “Standardizing Race, Ethnicity, Language and Tribal Affiliation Data: the New Mexico Experience.” Margy Wienbar, M.S., Director of Operations and Elayne Villa, Project Coordinator HealthInsight New Mexico

The work in New Mexico began under a contract with the New Mexico Department of Health (NMDOH). The state had reporting requirements in place for hospitals to collect and report race, ethnicity, and tribal affiliation data. The goal was to demonstrate improvement in health care disparities through stratified performance measures. The New Mexico team received training from George Washington University.

Ms. Wienbar provided a quote from the IOM justifying collection of race, ethnicity, and language data. It basically states that the absence of data guarantees that no action can be taken to reduce disparities. She proceeded to discuss a four-step approach --- 1) determine categories, 2) develop methodology, 3) train staff, 4) assign accountability and monitor progress --- to ensure successful collection of race, ethnicity and language (REAL) data. For New Mexico, she also added a “T” for tribal affiliation data. Data from New Mexico stratified by race, ethnicity and tribal affiliation demonstrate that there is a larger population of Native Americans, a lower population of African Americans and an equal number of Hispanics and Whites than in the U.S. as a whole.

Staff conducted training in data collection statewide in three phases and had to travel long distances. The pilot phase (2011) included observations and training in nine hospitals. The full rollout in 2012 included 39 hospitals and onsite training. Follow-up visits to assess implementation along with phone calls are in progress. The training emphasized a standardized approach to data collection. Some of the lessons learned include: the limitations of electronic systems to configure categories, especially tribal affiliation; the importance of front-line staff to understand the rationale for standardized data collection of race, ethnicity and tribal affiliation; the importance of asking for ethnicity affiliation first and the importance of individuals self-identifying; the value in seeing processes and data screens to help trouble shoot; the need to fit data collection into the flow of the registration process; and issues related to staff turnover.

Outcomes from the Hospital Inpatient Discharge Data (HIDD) Collection revealed that the built in quality safeguards required by the New Mexico Department of Health (NMDOH) increased data completeness in 2011-2012.

- Virginia - “Cardiac Disparities Data: Health Disparity Reduction Efforts”, Virginia Brooks, M.H.A, CPHQ, Virginia Health Quality Center (VHQC)

According to Ms. Brooks, Virginia is addressing cardiac disparities through a Learning and Action Network. The LAN includes medical experts, community partners, federal and state agencies, physician

offices and pharmacists, and focuses on aspirin therapy, blood pressure control and smoking cessation (ABCS) in 67 physician practices. Virginia analyzed data by gender and race to compare to national and state data to determine its focus. The data was also used to identify specific community partners. They found significant findings from the smoking data. For example, the data revealed that there were more male than female smokers and slightly more lack than white smokers. Yet, white females smoked more than black females.

VHQC's recommendations include using the EHR to capture disparity data, comparing findings with national trends from the CDC and state BRFSS data, and seeking assistance from a data analyst to perform statistical analysis. While they were able to work with only one of the two participating health systems due to the inability of one to pull the data, the team from Virginia was successful in targeting a specific intervention followed by identifying high and low performers. Going forward, they plan to visit practices to review data and trends, provide education to identified groups with demonstrated need, focus on a condition with high patient volume, and highlight findings in a newsletter.

- Panel Commentator: Maryland - Shanta Whitaker, Ph.D., M.P.H., Senior Disparities Analyst, Disparities national Coordinating Center (DNCC)

Dr. Whitaker summarized the QIOs' presentations and asked the QIOs critical questions about their data collection methods and future initiatives. Below are her questions to the panel and their responses.

1. How do you hope to make your data practices more sustainable?
 - New Mexico: The push coming from the NM Department of Health is vital because they are owners of a lot of data sets. They are really driving to standardize data.
 - Virginia: Our sustainability plans focus on teaching the value of data collection and standardization.
 - Kansas: We detached the disparities efforts from different projects. Therefore, the disparity efforts can remain consistent so that they are not tied to a single project. We train staff in the community so once we are done with the work, the effort can continue.
2. [Addressing the state of Virginia], do you have any plans to expand your studies/data collection methods to a more rural Virginia [beyond Richmond]?
 - Virginia: Our other projects focus on other parts of the state. To educate and expand our data collection methods, we stay involved with vendors, are part of their trainings, and make sure all staff is educated about the EHRs and know how to document.
3. What are the next steps/plans with the data? How do you plan to make this data relevant?
 - New Mexico: The data we are trying to standardize is data that is requested by the communities. A number of Native American communities are writing their own grants, they are looking for their own funds to be sustainable. So data is important to them. As we are able to do smaller area analysis, it will be very important to communities moving forward.

4. Have you asked the key stakeholders what is important to them?
 - o Virginia: We certainly have! We know that one of our groups is particularly focused on diabetes measures. They were already tracking diabetes measures, and they found out that they needed help with patients who had diabetes and hypertension. We were able to take a deeper dive and provide tools and interventions.

Keynote #3: Jie Chen, Ph.D., University of Maryland

Dr. Jie Chen: “Lessons from the Great Recession: Disparities in Health Care Costs.”

Dr. Chen described various ways that the recession of 2008 impacted patients served by conference attendees – loss of jobs, loss of homes, and loss of wealth. She hypothesized that the recession could have had different effects on various types of health care expenditures. Demand for primary care services (prescription drugs, physician visits, preventive care) might be more income sensitive compared to the demand for expensive health care services (high-intensity care, organ transplants, Magnetic Resonance Imaging, cancer chemotherapy). Using data from the Medical Expenditure Panel Survey (MEPS) for 2005-2006 and 2008-2009, she analyzed health care expenditures using quartile regression and difference-in-difference method. Results indicated that the 2008 recession was associated with significant drops in healthcare expenditure, particularly at the primary care level. At the same time, there was no significant relationship between the recession and health expenditures for more intensive medical interventions. Thus, less-expensive primary care expenditures decreased while expensive medical care, such as use of the ED, increased. Noteworthy is the fact that disparities persisted during the recession as racial and ethnic disparities became more pronounced at the primary care level.

Analyses of these data demonstrate importance of providing cost-effective treatments -- primary and preventive care and prescription drug use -- during economic crises. These findings point to the use of data to drive public policy. For example, the ACA provides for essential health benefits, expansion of Medicaid eligibility, and the health insurance marketplaces. All of the ACA provisions reduce the burden of healthcare spending for low-income families and help the effort to close racial and ethnic disparities in health care spending.