TAKE CHARGE for better health® series

REPORT 4:
Status Report on Efforts to Advance Health Equity

In Clinical Care and Health Outcomes
in Memphis and Shelby County, Tennessee

May 2011

Healthy Memphis®
COMMON TABLE

This **TAKE CHARGE** ***for better health***® report uses existing data for Memphis, Shelby County, the State of Tennessee and the United States to provide insight into the issues of health disparities in our community.

Healthy Memphis Common Table would like to acknowledge the Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative for supporting this report series through its grant.

This report was prepared by the Healthy Memphis Common Table and QSource with support from the Healthy Memphis Common Table Board of Directors, Advisory Committee, AF4Q Leadership Team and AF4Q Health Equity Committee.

Aligning Forces for Quality | Improving Health & Health Care in Communities Across Greater Memphis

An initiative of the Healthy Memphis Common Table and the Robert Wood Johnson Foundation.

Copies of this report will be available at: www.healthymemphis.org

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Foreword

To improve health care for everyone in Memphis, we must first understand the problem—the root causes of disparities in care. That's why the Healthy Memphis Common Table (HMCT) is pleased to introduce its fourth Take Charge for Better Health report. The goal of this report is to provide trusted information about health care disparities in Memphis and the socio-economic and structural causes of these disparities. To achieve equity, we cannot look at the health of an individual alone; we must also address the factors that give rise to and perpetuate certain social conditions.

We can only make improvements if we recognize where we stand as a community. To advance equity in health care, we must address the social determinants that create the inequities. According to the University of Wisconsin Public Health Institute's County Health Rankings, in 2010 and 2011 Shelby County ranked in the bottom third of most health indicators out of the 95 counties in Tennessee. The rankings are based on health outcomes (mortality and morbidity) and health factors such as health behaviors, clinical care, and social and economic factors.

Healthy Memphis Common Table is dedicated to making Greater Memphis one of the healthiest cities in America. As part of *Aligning Forces for Quality* (AF4Q), a national initiative of the Robert Wood Johnson Foundation to lift the quality of health care in 16 communities, we are working to measure and publicly report on the quality of local care, support health care providers as they learn how to deliver better care, and engage patients in making informed choices about the care they receive. As part of our AF4Q work, HMCT engages everyone who gives, gets and pays for care in Memphis to eliminate health disparities and achieve health equity. HMCT will continue efforts to mobilize the community, bring clarity to the problem and highlight the promise of achieving true equity in Memphis.

After considerable dialogue, deliberation and re-evaluation, we are excited to share this report, which demonstrates how where we live, work and play affects the kind of care we get as well as our health outcomes. In the upcoming months, HMCT will continue the dialogue around health equity with several organizations including the University of Tennessee's Consortium for Health Education, Economic Empowerment and Research (CHEER), The University of Memphis' Center for Health Equity Research and Promotion (CHERP) and the Shelby County Health Department (SCHD) to advance a coordinated effort. As co-chairs of the AF4Q Health Equity Steering Committee, we plan to broaden our conversations and include other individuals and organizations in our efforts to create a future state of health equity across Shelby County. As we strive to create better health for everyone, health equity holds the key and the promise for the greatest measure of our collective success.

We would like to send our appreciation to the Robert Wood Johnson Foundation for their financial support and technical assistance. We would also like to thank QSource and the local AF4Q Health Equity Steering Committee members for their contributions in writing and advising staff on the key elements of fostering this very important conversation in our community. We hope you'll join us in continuing this conversation about equity in Memphis.

Henry Sullivant, M.D. and Paula Jacobs - HMCT AF4Q Health Equity Steering Committee Co-Chairs

Executive Summary

This summary report provides information about the health care disparities or lack of health equity in Memphis and the socio-economic and structural causes of these disparities. Healthy Memphis Common Table has adopted the following definition of health equity combining those of the Association of State and Territorial Directors of Nursing and the Centers for Disease Control and Prevention: "Health equity is an ideal state marked by justice and fairness where everyone has the opportunity to 'attain their full health potential' and no one is disadvantaged from achieving this potential because of their race, ethnicity, socio-economic or other socially determined circumstances." To achieve equity, we cannot look at the health of an individual alone; we must also address the factors that give rise to and perpetuate certain social conditions.

Achieving health equity as a community goal is complex, but it is attainable with incremental steps. Using data from the 2010 County Health Rankings, this report details the path to health equity by describing the demographic and socio-economic determinants of health; identifying disparities in the delivery of clinical care services; stratifying local clinical care delivery performance measures by race, ethnicity and language; highlighting a local program to improve health outcomes for African Americans with diabetes; and establishing a set of recommended next steps to move the discussion into action.

HMCT produced this report with the support of the Robert Wood Johnson Foundation's Aligning Forces for Quality program. The aim of AF4Q is to improve the quality of health and health care in 16 communities across the country through implementation of systemwide transformative interventions at the local level. AF4Q addresses three main areas of health care improvement: quality improvement, performance measurement and public reporting, and consumer engagement. Embedded within each of these categories is health equity. Thus, efforts to identify and address racial and ethnic disparities in clinical care delivery are inherent in the model.

This report provides the foundation for how this model will better define key contributing factors of our current state of health disparities and opportunities to achieve our desired future state of health equity. The terms black, non-black and African-American are used interchangeably throughout this report and are based on the findings of the research or the Table referenced. Here are some key findings provided in this report:

1. The Memphis and Shelby County area has a growing population of various ethnic groups, especially those of color (Table 1). The most dominating issue is the high prevalence of poverty and poor health among many of these diverse groups.
2. The social and economic factors provide a snapshot of the rates of poverty, educational differences and income inequalities (Table 3). These factors are key drivers of the health disparities that exist in Memphis and Shelby County.
3. Access to care is noted as a complex issue of the lack of adequate transportation systems, uninsured and underinsured patients, Medicaid payment levels, and primary care provider shortage areas.
4. When looking at outcomes of care, various indicators note differences in leg amputation rates in diabetic patients according to racial lines (Table 5).

5. Noted differences in rates of mortality and chronic illness among the black and non-black population, as referenced in Table 5, continue to highlight disparities in all aspects of health and health care.
6. Initial studies by Methodist North Hospital on congestive heart failure patients has documented disparities between black and white patients. The findings are at the early stages of this study, but length of stay, rates of heart failure, onsite illness and survival rates among black and white patients demonstrate various disparities.
7. The efforts of HMCT and Memphis Healthy Churches in the Diabetes for Life project is noted as a promising approach to target African American Type 2 diabetics with a comprehensive intervention model. The project collects baseline information on how these efforts impact potential disparities in care.
8. Finally, HMCT's Board has endorsed a policy to provide a standardized manner in which to collect race, ethnicity and language (REL) data by all providers and enclosed a community-wide definition of health equity.

This information serves as a summary and continuation of HMCT's health equity work and provides a baseline for our efforts as a community to address disparities in health care and the impact on health outcomes. As a Regional Health Improvement Collobrative (RHIC), we must take systemic, community-wide action. This report provides a menu of suggested next steps to create HMCT's vision of health equity in Memphis and Shelby County. HMCT's vision of supporting Memphis in becoming one of America's healthiest cities means achieving better health and better care for everyone.

Reneé S. Frazier, M.H.S.A., FACHE
CEO, Healthy Memphis Common Table

What is a Regional Health Improvement Collaborative?

HMCT is the area's Regional Health Improvement Collaborative (RHIC), as certified by Health and Human Services as a Charter Value Exchange (CVE). This certification validates the value of a regional model of collaborations to address health and health care concerns. As an RHIC, HMCT engages various stakeholders, including business leaders, health plans, consumers, faith-based leaders, health departments, Quality Improvement Organizations (QIO), community groups and the health care provider community to address complex issues and create agreed-upon solutions. RHICs are recognized as a promising model of building capacity in a community to address various quality, population health and cost issues that comprise the current health of a community. HMCT is a member of the National Network of Regional Health Improvement Collaboratives, a national alliance that serves as a advocate for RHICs in the conversation of health care quality, population health, cost and health equity. More importantly, the model of RHIC is one of inclusive and broad-based partnerships across various stakeholders to leverage the collective assets of a community.

Introduction

We must deal with the social determinants of health to make Memphis and Shelby County, as well as our state, a healthier place to live, work, learn, play and heal.

The Healthy Memphis Common Table is a non-profit, 501(c)(3) Regional Health Improvement Collaborative that addresses both the health of everyone in the community and the health care delivery system. HMCT's vision is to support Memphis in becoming 'one of America's healthiest cities' by mobilizing action to achieve excellent health for all. The four strategic imperatives are:

- To promote healthy lifestyle changes;
- To disseminate preventive care messaging for the general public;
- To develop consumer-friendly health and quality public reports;
- To advance environmental policies that focus on health equity.

Steering Committees are made up of employers, health plans, physicians, hospitals, faith-based leaders, neighborhood leaders, consumers and consumer advocates who work to create common solutions that result in health care quality improvement, health equity and better health outcomes for everyone.

In 2006, HMCT received a grant from the Robert Wood Johnson Foundation's Aligning Forces for Quality program. The aim of AF4Q is to improve the quality of health and health care in 16 communities across the country through implementation of systemwide transformative interventions at the local level. AF4Q addresses three main areas of health care improvement: quality improvement, performance measurement and public reporting, and consumer engagement. Embedded within each of these categories is health equity. Thus, efforts to identify and address racial and ethnic disparities in clinical care delivery are inherent in the model.

What is AF4Q?

Healthy Memphis Common Table is part of Aligning Forces for Quality (AF4Q), the Robert Wood Johnson Foundation's signature effort to help lift the overall quality of health care in the United States. Memphis joins 15 other communities across the country that are committed to performance measurement and public reporting as a cornerstone to achieving high-quality, patient-centered care that is equitable and affordable. By publicly reporting on important markers of quality care, HMCT's AF4Q work informs consumers about how to get the best care possible for themselves and their families, and helps physicians identify areas for improvement of the care they deliver. The data is available to everyone at www.healthcarequalitymatters.org.

In our third round of funding from the Robert Wood Johnson Foundation, inequities in clinical care delivery will be identified through the systemwide and systematic collection of data on the Race, Ethnicity & Language (REL) preferences of consumers in hospital and ambulatory settings. The expectation is that by stratifying care indicators by the REL data, we can measure the quality of clinical care against local, state and national standards and quality improvement efforts can be identified and implemented, leading to decreased disparity in the health outcomes of community residents.

To move from identifying disparities to advancing efforts and eventually achieving health equity requires a clear definition of the term. The local AF4Q Health Equity Steering Committee, the Leadership Team and the HMCT Board of Directors adopted a definition of health equity in April 2011. After a review of several publications and much discussion, a definition combining those of the Centers for Disease Control and Prevention and the Association of State and Territorial Directors of Nursing was proposed and accepted. The HMCT defines health equity as follows:

> "Health equity is an ideal state marked by justice and fairness where everyone has the opportunity to 'attain their full health potential' and no one is disadvantaged from achieving this potential because of their race, ethnicity, socio-economic or other socially determined circumstances."

Achieving health equity as a community goal is complex, but it is attainable with incremental steps. Using the 2010 County Health Rankings, this report details the path to health equity by:

- Describing the demographic and socio-economic factors that impact the health of Shelby County and Memphis resident population;
- Identifying disparities in the delivery of clinical care services using secondary data;
- Stratifying local clinical care delivery performance measures by race, ethnicity and language;
- Highlighting a local program to improve health outcomes for African Americans with diabetes;
- Establishing a set of recommended next steps to move the discussion into action with the ultimate goal of advancing health equity within clinical care delivery and community settings.

Health Equity:
Health equity is an ideal state marked by justice and fairness where everyone has the opportunity to 'attain their full health potential' and no one is disadvantaged from achieving this potential because of their race, ethnicity, socio-economic or other socially determined circumstances.

Health Disparities:
The disproportionate burden of disease, disability and death among a particular population or group when compared to the proportion of the population.[1]

Memphis and Shelby County: Indicators of Socio-Economic Factors Affecting Health

There are demographic and socio-economic factors of the Shelby County and Memphis population that clearly impact individual and population health. As the County Health Rankings project states, "where we live, work, learn and play affects our health."[2] Various indicators presented in this section provide context for the observed disparities in clinical care delivery measures as well as in health outcomes.

Throughout this report, we will make comparisons between Memphis, Shelby County, Nashville, Davidson County, the State of Tennessee and the United States as a whole to provide context and draw conclusions about Memphis and Shelby County's overall health and the how it is affected by geographical, demographic and environmental factors.

Total Population

With an estimated 2009 population of 918,186, Shelby County is the largest county in the State of Tennessee. In the same year, Memphis, the county's (and the state's) largest city, had a population of 679,052, representing almost 74 percent of all County residents. However, much of Memphis' population growth in the last decade has been due to annexation. Shelby County's population grew at a meager rate of 2.5 percent between 2000 and 2009 compared to the 10.7 percent increase experienced by Tennessee and the 11.5 percent increase experienced by Davidson County in the same period.[3] The Memphis Metropolitan Statistical Area (MSA), which includes eight counties straddling three states, has experienced growth in the last 10 years, indicating that the counties outside of Shelby County are growing while Shelby falters.[4]

Gender and Age

Shelby County's population has a higher proportion of females (52.3%) to males (47.7%) than trends observed nationally (50.7% vs. 49.3%), statewide (52.0% vs. 48.0%) or compared to Davidson County (51.5% vs. 48.5%). The gender distribution of the Memphis population is similar to Shelby County's.[5] The higher proportion of females compared to state and national averages may be explained by a number of factors, including a high rate of mortality among the male population.

The median age of Shelby County's population is estimated at 34.1 years. Although this is similar to the 34.0 years median age for Nashville and slightly lower than the 34.3 years of Davidson County, it is nonetheless almost two years higher than Memphis' median age of 32.7 years. Tennessee's median age is 37.3 years. Memphis' lower median age is explained by the fact that almost 66 percent of Memphis'

population is 44 years and younger.[6] Depending on the health status of this young population, there are significant implications for the clinical care delivery system to respond to the needs of this cohort of the Memphis population.

Race, Ethnicity (Nativity) and Language

Table 1 shows the racial and ethnic composition of Shelby County and Memphis' population compared to Nashville and Davidson County. Shelby County has a diverse population. The percentage of African Americans is greater than in Davidson and Nashville. Fifty percent of the Shelby County population is African-American compared to only 12 percent nationally, 16.5 percent statewide and 27 percent in Davidson County. In Memphis, the African-American population represents 60 percent of the city's residents; they represent about half of that in Nashville. The Memphis rate of 60.8 percent is 10 percentage points higher than in Shelby County, indicating that most African Americans living in Shelby County live in Memphis, also known as the urban core.

The Shelby County Latino population is now estimated at almost 5 percent, nearly double the rate in 2000. The current percentage is still smaller than both the national and Davidson County figures.[7] As a percentage of the population, there are more Latinos in the City of Memphis (5.2%) than in Shelby County (4.5%). Nationally, the Latino population represents 15.1 percent of the total U.S. population. This is almost three times the rate observed in Shelby County and almost four times that observed in Tennessee (3.7%).[8]

Table 1. Racial Composition by Geographic Designation

	Memphis	Shelby County	Nashville	Davidson County
Total Population	679,052	918,186	592,497	621,465
Race (as % of the population)				
One Race	98.7%	98.7%	98.89%	98.6%
White	33.3%	43.4%	67.7%	65.8%
Black or African American	60.8%	50.6%	28%	27%
American Indian/Alaska Native	0.2%	0.2%	0.3%	0.3%
Asian	1.7%	2.2%	3.1%	3.1%
Native Hawaiian/Pacific Islander	0.1%	0.1%	0%	0.1%
Some Other Race	2.6%	2.2%	2.6%	2.5%
Two or More Races	1.3%	1.3%	1.2%	1.2%
Hispanic or Latino (of any race)	5.2%	4.5%	8.1%	7.9%

Source: U.S. Census Bureau. 2005 – 2009 American Community Survey, 5-year Estimates

Shelby County has a small proportion of Asians compared to that of the U.S. or even that of Davidson County, but still higher than the proportion of Asians living in Tennessee as a whole. Although Table 1 reveals that Shelby County has a higher proportion of Asians compared to Memphis, 11,544 (57%) of the 20,200 Asians in Shelby County live in Memphis.

As Table 2 reveals, Memphis and Shelby County have a lower proportion of non-U.S. born residents *("foreign born")*, contributing to why Memphis has a lower rate of foreign-language use inside the home compared to that observed in Nashville and Davidson County. However, a closer analysis of the statistic reveals that compared to those in other geographic designations, there is a higher proportion

of foreign-language speakers in Memphis who do not believe they speak English very well. This issue of English literacy has implications on the ability of these foreign-language speakers to access the necessary clinical care services and assure adherence and compliance with instructions from clinical care providers. Additionally, this puts this cohort of the population at risk of lowered access to social, health and economic services, thereby potentially exacerbating health challenges they may already have.

Table 2. Nativity (Ethnicity) and Language Use by Geographic Designation

	Memphis	Shelby County	Nashville	Davidson County
Place of Birth				
% Native Born	94.4%	94.5%	89.1%	89.3%
% Foreign Born	5.6%	5.5%	10.9%	10.7%
Population 5 yrs. & Over, Language Spoken at Home				
% English Only	91.9%	92%	85.9%	86.2%
% Language Other Than English	8.1%	8.0%	14.1%	13.8%
% Who Speak English "very well"	4.6%	3.9%	7.1%	7%

Source: U.S. Census Bureau. 2005 – 2009 American Community Survey, 5-year Estimates

According to Census numbers, there is a growing concentration of people of color within Memphis. In the United States, people of color living in the urban core tend to be poor, uneducated or undereducated, and have increasingly inadequate skills to participate in a more complex economic system. This results in increasing poverty, which has tremendous health and economic consequences to them and the community as a whole.[9]

The persistent high incidence of poverty among people of color, specifically among African Americans, has been explained by the historical and structural allocation of economic resources from policies that disfavored African Americans. These include the Homestead Act of 1862, the G.I. Bill of 1944, the Housing Act of 1949, as well as transportation/highway expansion and mortgage practices. The resulting segregation of neighborhoods by race and consequently by income indicates growing social disintegration with dire consequences to the health and well-being of the residents.[10,11] The increasing role of racial discrimination has also been posited as an explanation for disparities in health outcomes because of its role in increasing stress levels, stress' effects on metabolic pathways and consequently, overall health and well-being.[12,13]

Socio-Economic Factors

The County Health Rankings attempt to provide measurements of the socio-economic factors that have been shown to impact the health of an individual and populations. Table 3 below outlines the ratings for Shelby County and compares them to Davidson County, Tennessee and the County Health Rankings target.

As Table 3 reveals, the socio-economics of Shelby County do not help its residents achieve good health outcomes. On almost every indicator, Shelby County is worse than Davidson County, the State of Tennessee and the County Health Rankings target. The U.S. Census Bureau data indicates Memphis' unemployment rate of 7.5 percent compared to Shelby County's 7 percent. College degrees were

obtained by only about 14.2 percent of Memphis' general population and only 30.6 percent graduated high school, representing less than half of the level achieved by the Shelby County population as a whole. These socio-economic characteristics are likely causes of the Memphis population's poor health.

New research findings suggest that the interplay of the social characteristics of race, gender and social class influences health outcomes "(1) by shaping exposure to risk factors, events and processes; (2) by shaping exposure and susceptibility to protective factors, events and process; (3) by shaping access to and type of health care provided; and (4) by shaping health research and health pathways." [14]

Table 3. Socio-Economic Factors Contributing to Population Health by Geographic Designation

	Shelby County	Davidson County	Tennessee	National Target
High School Graduation	67%	62%	71%	84%
College Degrees	27%	32%	22%	23%
Unemployment	7%	5%	6%	6%
Children in Poverty	30%	24%	23%	17%
Income Inequality	50	48	47	41
Inadequate Social Support	19%	18%	19%	12%
Single-Parent Households	15%	11%	10%	7%
Violent Crime Rate (per 100,000 people)	1529	1437	755	204

Source: 2010 County Health Rankings

All the above-mentioned demographic and socio-economic characterizations of the Shelby County and City of Memphis population, especially for people of color, suggests that the county and city residents are at high risk of experiencing (and may already be experiencing) poor health and well-being from diabetes, asthma, cardiac disease, cancer, HIV/AIDs and other diseases long before they access the clinical care system. It will come as no surprise that the health outcomes of this population will register a disparity compared to their non-African American counterparts. Despite this predicament, improving the quality of clinical care and making quality care equitable is a community goal that can be achieved with relevant and meaningful data to guide the efforts. The stratification of clinical care performance measures by REL data is a prerequisite for identifying the opportunities for improvement and intervention. With additional consideration for the geographic distribution of health and disease, this serves as the basis for identifying interventions and mobilizing local efforts to improve the health of Memphis and Shelby County residents, especially the urban poor.

Surveying for patient Race, Ethnicity & Language (REL) data will help us identify trends in care disparities so we can target problems and achieve better equity.

Importantly, doctor and hospital staff must explicitly ask patients for their REL data rather than "eye-balling" or guessing because such practices are extremely unreliable.

Identifying Local Clinical Care Delivery Disparities Using Secondary Data

Research on Race, Ethnicity & Language data sources indicates that there is a lack of reliable primary data depicting disparities in the delivery of clinical care services in Memphis and Shelby County. This is not unusual, as the collection of REL preference of clinical care service clients is not systematically collected at a national or local level.

Access to Care

Using the primary care provider rate as an indicator of access to care, Table 4 below shows that Shelby County seems to have better access to care than Tennessee and the national target but much worse access than in Davidson County, although statistics do not tell the whole story.

Access to care includes a person's health insurance status as well as their ability to visit a doctor when they need one.

The recent study by the University of Memphis Center for Healthcare Economics calculates that about 74,000 or more uninsured non-elderly adults will enter the clinical care system as a result of the Patient Protection and Affordable Care Act, also known as the health reform bill. This influx of uninsured county residents into the system reduces the percentage of uninsured in Shelby County by almost half, but it will require some 24 primary care physicians or other allied health worker counterparts to care for the additional clientele.[15] This calculated need for medical personnel highlights the system's deficiency in serving the needs of the residents who have insurance but does not account for the lack of personnel to serve those without insurance, who are perhaps even more infirmed than those with insurance. Given the population of Memphis and Shelby County, one can conclude that most of those without insurance and therefore without access to clinical care services are the urban poor, and consequently African Americans and Latinos.

Table 4. Clinical Care Indicators by Geographic Designation

	Shelby County	Davidson County	Tennessee	National Target
Primary Care Provider Rate	139	181	121	125
Uninsured Adults	16%	17%	15%	12%
Diabetic Screening	78%	82%	82%	88%

Source: 2010 County Health Rankings

To further complicate the issue of access to care, economically disadvantaged inner-city residents (who are predominantly people of color) do not have reliable or adequate transportation to get them to physicians. Although there are Federally Qualified Health Centers (FQHCs) in some areas where the urban poor live, they are not uniformly accessible by public transportation or by walking. It is important to note the efforts of Christ Community Health Services as they plan to expand their facilities to provide primary care access in communities that lack these critical services, as well as the Memphis Health Center (MHC) whose service to our community has been longstanding. Even though MHC has not announced plans to expand, it remains a key asset in providing primary care services to a very vulnerable population.

Most private primary care physicians hold offices away from the urban core.[16] Additionally, even when public transit services are available, residents who do not have the economic means may still be disinclined to go to primary care facilities. There are a few private primary care practices who remain in the urban core, but the trend continues to be for private physicians to relocate to the more affluent areas of our community.

High-quality primary care is a major goal of HMCT's participation in AF4Q. HMCT works collaboratively with the Memphis and Bluff City Medical Societies to address how to improve access to high-quality health care and reduce the unnecessary and inappropriate use of our emergency rooms. Access to primary care involves embracing the use of other key clinical personnel like nurse practitioners to address some of our access issues. The work of the Church Health Center to address access for the working poor is a unique model of providing services to an underinsured population in Memphis. The Loop Health Centers, operated by the Regional Medical Center, are also a key element of ensuring we have needed access in our urban areas. In addition, the University of Tennessee Medical Group, located in Memphis, is the largest multi-medical specialty care group and provides the safety net of providers to maintain a core of physicians and other clinicians to ensure there is a referral base for primary care providers.

Did You Know?
The Memphis Aligning Forces for Quality program focuses on improving health care for patients with chronic diseases – especially diabetes, cardiac disease and pediatric asthma.

The Memphis and Shelby County communities understand the complex issues of access and, as a result, are addressing access issues through ongoing, community-wide health fairs. Health fairs have become an effective response by hospital, faith-based, and community organizations to provide needed outreach to vulnerable populations. These health fairs provide an initial entry point for many poor and underserved communities to have access to preventive screenings of various chronic illness and promote appropriate primary care follow-up.

Access to high-quality primary care is an on-going focus on our community efforts. Memphis and Shelby County must address these gaps in access to care because this issue fosters our current undesirable health disparities.

Ambulatory Care Measures

Table 5 depicts ambulatory care measures for the Memphis Hospital Service Area (HSA) using data from the Dartmouth Atlas of Health Care and compares Memphis data with state and national level data. The Memphis HSA extends beyond the geographical boundaries of Memphis and Shelby County. The ambulatory care measures include: (1) annual visits to a primary care clinician; (2) mammogram; (3) leg amputations; (4) diabetes management measures including blood lipid tests, annual eye exam and Hemoglobin A1c monitoring. The data presented compares the data between the black and the non-black population in these geographic designations. The data set reflected by Table 5 are for the years 2006-2007.[17]

Table 5 reveals disparities between the level of ambulatory care received by the black population, compared to the non-black population in the Memphis HSA in a number of indicators. The variance, on average, is over five percentage points in four out of five indicators. The data also reveals that the level of care of the black population in the Memphis HSA is below those observed in the cohort

If you are black and live in Memphis, you are more than three times more likely to have your leg amputated due to complications from diabetes than if you are non-black.

at the state and national levels. Using the measure of annual visits to a primary care clinician as an indicator, the table reveals that the black Medicare population in our area visit their primary care clinician at a much lower rate than their non-black counterparts. In Memphis, this suggests barriers such as cost, proximity of primary care clinician and availability of transportation services.

Because diabetes is a major focus of the HMCT's AF4Q program, HMCT looks to diabetes measures for disparities in the quality of clinical care. As Table 5 below shows, measures for the management of the disease such as regular screenings for blood lipids, eye exams and HbA1c's are not conducted as regularly for black residents as they are for non-black residents. In the Memphis HSA, this disparity is more pronounced than those in the black population of Tennessee and the U.S. This suggests that the black diabetic population in Memphis and Shelby County are experiencing devastating consequences such as an increased proportion of leg amputations compared to the non-black diabetic population, as Table 5 shows.

Table 5. Ambulatory Care Quality Measures by Race and Geographic Designation

	Memphis HSA		Tennessee		United States	
	Non-Black	Black	Non-Black	Black	Non-Black	Black
Annual Ambulatory Visit to PCC	77.8%	72.1%	82.1%	74.5%	78.7%	71.1%
Diabetes Management - Blood Lipids Test	77.2%	67.1%	80.2%	69.4%	79.7%	71.9%
Diabetes Management - Eye Exam	62.3%	56.7%	63.6%	59.9%	58.1%	62.7%
Diabetes Management - HbA1c	83.4%	76.6%	84.6%	79%	82.1%	77.9%
Leg Amputations*	0.7	3.5	0.9	3.6	0.7%	3.4%
Mammograms**	57.9%	55.8%	62.1%	58.1%	64.1%	57%

* Per 1,000 Medicare Enrollees
** For Women Ages 67-69
Source: The Dartmouth Atlas of Health Care

Mammograms are also a problem area for equity. Mammograms are a preventive measure against breast cancer but are disproportionately underutilized by black women; this results in a disproportionate number of deaths resulting from breast cancer throughout this population, as Table 6 reveals.

Shelby County's overall cancer death rate is much higher than Davidson County, the state of Tennessee, and even the nation as a whole. This may be due in part to lower levels of cervical cancer screenings and mammography exams in the African-American community, which harkens back to problems of access to care for those populations in Memphis.

Cancer Deaths

According to the State Cancer Profiles' women's cancer measures, Shelby County's cancer mortality rate is much higher than Tennessee's or the United States'.[18] Table 6

shows the cancer death rate comparison between Shelby County, Davidson County, Tennessee and the U.S. Factors such as lack of access to care, low number of visits to primary care physicians and lower rate of mammograms may explain the high rate of mortality from cancer.

Again, when looking at the burden of cancer mortality in Shelby County and considering the demographic and socio-economic profile of its resident population, it appears that people of color disproportionately experience a higher mortality in various types of cancers. In addition, studies in environmental justice show a disproportionate number of people of color living within 1.8 miles of the nation's commercial hazardous waste facilities[19] that may cause some types of cancer. This is another potential factor leading to the differences in death rates by cancer found by geography and race.

Table 6. Cancer Death Rates By Geographic Designation

	United States	Tennessee	Shelby County	Davidson County
Overall Cancer Death Rate*	183.8	206	215.4	195.7
Breast Cancer *	24	25.4	32.5	25.2
Cervical Cancer*	2.4	2.8	3.9	1.9

*Deaths per 100,000
Source: State Cancer Profiles: Death Rate Report for Tennessee by County, Death Years Through 2007

Immunizations

Infectious diseases continue to be a major cause of preventable hospitalizations and death. The Healthy People 2010 goals for immunization and infectious diseases are rooted in evidence-based clinical and community activities and services for the prevention and treatment of infectious diseases. Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package.

Immunization data from two different sources support the same trend observed among the African-American populations accessing health care services. As Table 7 shows, there is a lower rate of immunization for African-American adults aged 65 and over in the U.S. than for the same age cohort in the total population. Even among health care personnel, African-American health care professionals do not receive vaccinations as much as the overall population.[20]

Table 7. Adult Vaccination Coverage: National Population Versus Black/African American National Population

	Overall Population	Black/African-American Population
Immunization: Flu*	65.6%	50.8%
Immunization: Pneumonia*	60.6%	44.8%
Immunization: Flu**	52.9%	39.8%

*Adults aged 65+ who have had a flu/ pneumococcal polysaccharide vaccine (PPV) shot within the past year
**Proportion of Health Care Personnel who received vaccinations within the past year
Source: 2009 National Health Interview Survey

Current Efforts to Stratify Clinical Care Delivery Performance Measures by Race, Ethnicity and Language

The annual National Healthcare Disparities Report (NHDR) shows that disparities persist for specific population groups.[21] Investigations to study racial disparities in hospitals, nursing homes and physician practices are frequently conducted and published; however, data are generally limited to statewide results due to the inadequacy of REL data collection at the regional and city level. The NHDR has proposed that disparities reported at the state level may hide opportunities to reduce disparities in Shelby County.

For example, a study by Grabowski and McGuire on nursing home minimal data concluded that they did not find disparities across the majority of quality measures within a single nursing home.[22] However, there were variations across facilities suggesting that where the Medicare enrollees seek care directly influences the quality of care they receive.

Healthy Memphis Common Table provides performance reports for Memphis doctors' offices at www.healthcarequalitymatters.org.

This section outlines current local efforts to identify clinical care disparities through the stratification of clinical care delivery measures by REL preference. The HMCT's AF4Q activities and those of the Equity Quality Improvement Collaborative (EQIC) of Methodist Hospital Systems, a project funded by the Robert Wood Johnson Foundation, will be described.

HMCT's AF4Q Activities

During 2010, HMCT conducted an evaluation of 120 practices and 330 individual physicians, focusing on nine quality measures in four clinical domains as shown by Table 8. The table indicates that for at least two indicators for comprehensive diabetes management, Shelby County achieves higher ratings than the U.S. benchmark. The low marks for eye exams impacts the County Health Rankings' below-the-national-benchmark rating for diabetes care in Shelby County.

Table 8. Performance Measures by Clinical Domain

Clinical Domain	Performance Measure	U.S. Benchmark	Shelby County Benchmark
Heart Disease	Persistence of Beta Blockers post MI (PBH)	N/A	N/A
	Cholesterol Managment for Patients with Cardiovascular Conditions (CMC)	N/A	N/A
Comprehensive Diabetes Care for Adults	HbA1c Test (CDC-HbA1c)	83.3%	88.3%
	Cholesterol (LDL-C) Screening Test (CDC-LDL)	78.6%	81.1%
Pediatric Care	Eye Exam (CDC-EYE)	46.6%	42.1%
	Well-Child Visits (Ages 3-6 years) (W34)	66.6%	58.4%
Women's Health	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	N/A	N/A
	Breast Cancer Screening (Ages 40 to 69) (BCS)	N/A	N/A

Source: Healthy Memphis Common Table. Patient Experience Survey, 2010.

An initial clinical quality performance survey was conducted throughout Greater Memphis in January 2009. While small in sample size, the results of the study indicated the collection of REL data in Shelby County is sporadic and frequently relies on collection methods such as "eye-balling" or discerning race via evaluation of the surname. These techniques are highly unreliable for ascertaining accurate data. In an effort to inform the community about how the collection of REL data assists in identifying disparities in clinical care measures, HMCT and the AF4Q national program office conducted a "Patient Registration Training on the Collection of REL Data" seminar, held in October 2010. This half-day training explained the need and the process for collecting REL data appropriately. Documents from this training are currently available on the www.healthymemphis.org website.

As a result of the feedback from this training, the AF4Q Health Equity Steering Committee resolved to follow the Institute of Medicine's recommendations on collection of clinical care delivery measures using standardized REL categories and have adopted an REL policy. Utilization of this data is the fundamental first step in developing the capacity to compare Memphis and Shelby County's clinical care delivery measures with the rest of the state and the nation.

HMCT's commitment to address disparities in clinical care delivery, as part of the efforts of AF4Q, supports stratification by standardized race, ethnicity and language categories in both hospital and ambulatory settings. Memphis lacks data for most measures. However, in late 2009 HMCT and QSource attempted to evaluate the availability of this data with a survey. The survey's goal was to elicit information on how REL data can be collected and aggregated for potential use in identifying disparities in the delivery of clinical care.

Equity Quality Improvement Collaborative

In the fall of 2009, HMCT recruited Methodist North Hospital to participate as one of seven hospitals in the Robert Wood Johnson Foundation's EQIC initiative as part of AF4Q. All hospitals in the area were asked to consider this effort and Methodist North accepted. EQIC identifies and tests ways for hospitals to improve the quality and efficiency of their cardiac care, while also identifying and reducing racial and ethnic disparities.

Methodist North Hospital examined its own processes for how well they delivered heart disease care by patient's race, ethnicity and language. The study results indicated that equity is assured in the measures of ideal care; however, disparities were evident in several measures associated with the condition, prevalence and outcome.[23]

- Disparities in Length of Stay (LOS) for cardiac care:
  - Black heart attack patients were discharged 1.37 days earlier than white patients.
  - Black heart failure patients were discharged 1.5 days earlier than white patients.

- Disparities in readmission rates in heart failure:
  - White patients were 32% more likely to be readmitted within 30 days.

- Disparities in age of illness:
  - Black patients hospitalized for heart failure were 15 years younger than white patients.
  - Black patients hospitalized for heart attack were 9 years younger than white patients.

- Disparities in survival odds:
  - The survival odds were higher, i.e., the mortality rates were lower, for black patients hospitalized for either cardiac condition.
  - However, black patients were more likely than white patients to experience sudden collapse outside the hospital.
  - Black patients were also more likely than white patients to experience death at a younger age.

To ensure coordination of local efforts to measure health care disparities, the staff at Methodist North Hospital presented on the problem of health care disparities in Memphis to an audience of more than 100 people at a HMCT meeting. The audience expressed concern about asking for patients' demographic information at registration. Methodist North Hospital staff assured the group that this is the only way to pinpoint disparities—citing existing evidence and data—by taking the steps needed to develop targeted innovations. They outlined the hospital's plans to implement a program to collect data on patients' race, ethnicity and preferred language. Everyone in the audience was called on to educate their constituents about inequalities in care, the steps needed to reduce them, and the changes occurring at Methodist North to make health care more equitable. The Methodist Le Bonheur Hospital system has adopted HMCT's endorsed policy of collecting REL data across the system. This will provide the organization with a consistent manner of documenting various areas of disparities by diagnosis and position opportunities to create appropriate interventions.

In the coming months, HMCT will work with all hospitals, physicians and clinics to adopt this standardized REL policy. The intent is to gain community-wide acceptance, and advance the need to address these disparities, and most importantly, provide solutions.

Diabetes for Life: A Local Approach

HMCT and Memphis Healthy Churches have partnered to address the diabetes epidemic in our community through a grant funded by The Merck Foundation's Alliance to Reduce Disparities in Diabetes.[24] The Diabetes for Life (DFL) program is geared toward care management of African-American diabetic patients in Memphis who are 18 years of age and older and have been diagnosed within the past 10 years. There are more than 300 people enrolled in the program, approximately two-thirds of whom are women.

DFL has helped participants lose weight, lower their A1C (blood sugar), blood pressure and cholesterol levels, and learn about the long-term care for diabetes through self-management. In addition, DFL addresses disparities in care by:

- Implementing a proven, evidence-based chronic disease self-management program that can be offered to people with diabetes as part of a comprehensive approach to

management and care;

- Increasing access to and utilization of programs and resources to promote and maintain patient weight loss, including diet and nutritional counseling, peer support groups, and access to various exercise options based on patient preferences and needs;
- Offering case management support for people with diabetes and their families to help them gain access to and better utilize health resources as well as adopt and maintain effective disease self-management and lifestyle changes;
- Fostering ongoing implementation of standard quality management and clinical improvement procedures to ensure that all patients at participating community health centers receive appropriate screening and treatments for diabetes and related chronic illnesses; and
- Enhancing provider cultural competency and communications training, as well as related patient feedback processes, to measure effectiveness and appropriateness of provider communication.

The DFL project's primary focus is to ensure patients receive evidence-based medical care coupled with a comprehensive array of culturally appropriate support services. The project will serve as the basis for how HMCT will support our community-wide efforts to eliminate long-standing disparities in care and health outcomes of Memphis and Shelby County African Americans with Type 2 diabetes.

Dr. Augustus A. White is professor of Medical Education and Orthopedic Surgery at Harvard Medical School, and the author, with David Chanoff, of "Seeing Patients: Unconscious Bias in Health Care." Dr. White visited Memphis, Tenn., his hometown, on March 29, 2011 and provided several presentations to the community.

After growing up in the Jim Crow-era of the South, Dr. White went on to become the first African-American graduate of Stanford University's medical school, and later the first African-American department chief at Harvard's teaching hospitals. "Seeing Patients" draws on both original research and Dr. White's own experiences to examining how care is affected by the unconscious prejudice of providers. In his book, Dr. White explains how his own experiences led him to think about the biases we all have, medical disparities that arise from those biases, and their impact on health care for everyone – including Latinos, women, the elderly, gay people, and for others who differ from the mainstream.

In his book, Dr. White writes, "Peer review journals confirm a substantial disparity in health care for minorities in America today. The infant mortality rate for blacks is more than twice that for whites. African Americans receive fewer cardiac catheterizations, fewer angioplasties, fewer bypass surgeries, fewer kidney transplants, fewer lung cancer surgeries. African Americans and Hispanic Americans with long bone fractures are significantly less likely to receive pain medication than whites. African Americans receive more hysterectomies, more amputations, and more bilateral orchiectomies (castrations). The death rate for nine of the top 10 causes of death in America is at least 1.5 times greater for blacks than whites...Professor Jack Gieger at CUNY Medical School has reviewed 600 citations documenting disparities in the treatment of African Americans and Hispanic Americans. They suggest strongly that physician bias and stereotyping, however unconscious, is the cause." (pgs. 3-4)

Conclusions and Next Steps for 2011

To improve health outcomes for the population of Memphis and Shelby County, we must take action to address the structural factors that lead to poor health and illness even before residents visit their health care providers. HMCT believes this is the most important factor in advancing our community to health equity. Demographic, geographic and socio-economic characteristics work against residents' ability to access resources and put them at risk for behaviors and environments that are contrary to good health and well-being.

There are a number of local efforts afoot to identify disparities in clinical care quality. HMCT's efforts include the stratification of clinical care measures by race, ethnicity and language to ensure equity in the delivery of the care. These findings must be translated into population- and location-based health promotion interventions that, along with efforts to identify disparities in clinical care delivery, create equity.

The following systemic, community-based and individual-level steps are necessary to pursue health equity in both clinical care and community settings:

1. Standardize the collection of REL data as a regionwide initiative, including establishment of a policy for hospitals and physicians to adopt as part of their daily practice.
2. Provide education and community forums to move toward an expansive and progressive conversation and implementation strategy on health equity.
3. Evaluate existing measures to address health disparities in all AF4Q Steering Committees and Workgroups and integrate a shared vision of health equity.
4. Collaborate with the local health information exchange and review national emerging data collection and performance measurement tools.
5. Identify the utilization and availability of mammography testing at the local level.
6. Convene meetings with the Shelby County Health Department, University of Tennessee's Center for Health Education, Economic Empowerment and Research, and University of Memphis's Center for Health Equity Research and Promotion.
7. Partner with all hospitals in the community regarding results of REL data collection and strategies for quality improvement.
8. Activate a "color conscious" rather than a "color neutral" approach to race, ethnicity and language awareness.
9. Organize forums and discussion groups to explore the concept of privilege and the impact on target or non-dominant groups.
10. Recommend local residents attend "Common Ground - Conversations on Race" offered by the YWCA of Greater Memphis and other forums that support communication, listening and understanding.
11. Collaborate with local literacy organization(s) to support the development of health literacy for non-English speaking community members.
12. Adopt the National Stakeholder Strategies launched by the U.S. Department of Health and Human Services as a support to our local efforts to address a future state of health equity. The National Stakeholder Strategy for Achieving Health Equity was launched on April 8, 2011 and can be reviewed at www.hhs.gov.

These steps will help advance HMCT's vision of making Memphis one of America's healthiest cities by mobilizing the community's resources for the excellent health of all. Our hope is that this report is the beginning of a broader and wider community dialogue about the need to improve the health factors that impact individual and population health.

The health of our residents is determined
by where we live, work, learn, play and heal.
We believe it is time for a new vision
for our community and we ask you to join us
in our quest to make Memphis
"One of America's Healthiest Cities."

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