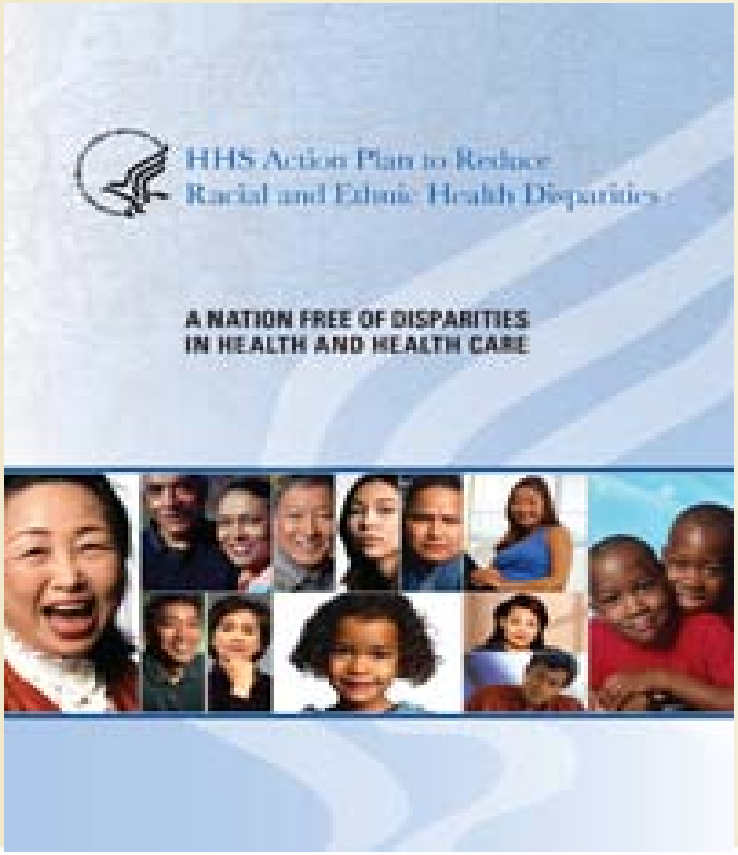
Patient Centered Outcomes Research (PCOR), the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, and the National Stakeholder Strategy

HHS Action Plan to Reduce Racial and Ethnic Health Disparities

The overriding intent of the goals, strategies and actions in this plan is to generate national momentum toward health equity by aligning resources of HHS in focused efforts to reduce racial and ethnic disparities.

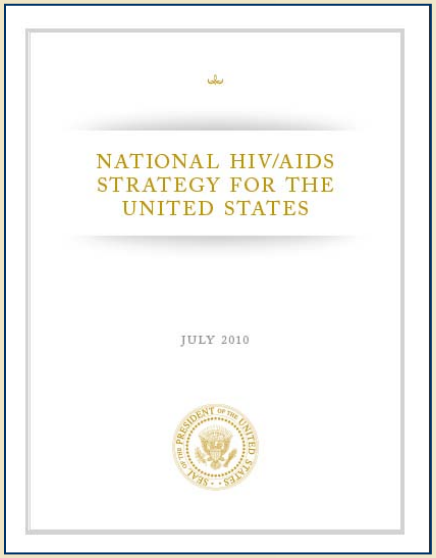


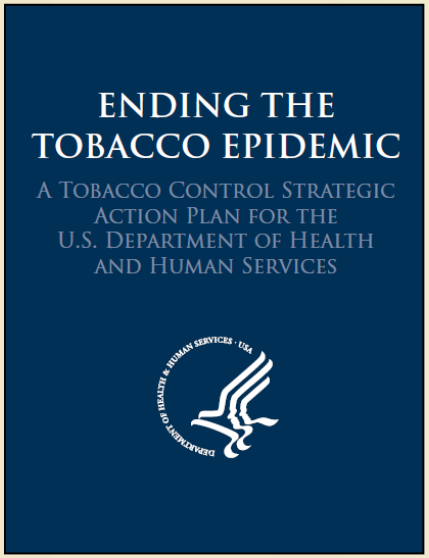
What is the HHS Action Plan?

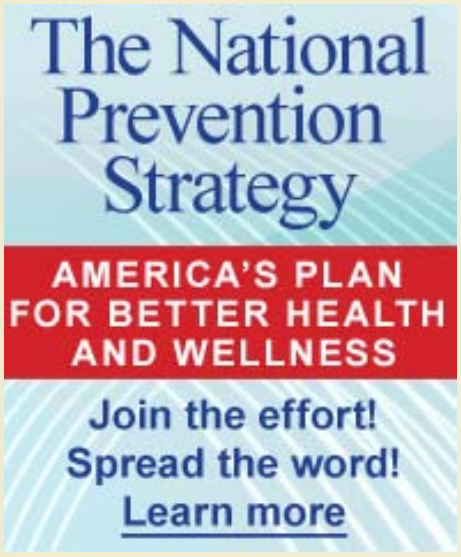
- A Department-wide response and complement to the National Stakeholder Strategy for Achieving Health Equity
- First ever HHS Action Plan to reduce health disparities - builds on health disparity reduction provisions in the Affordable Care Act
- A set of Secretarial priorities, pragmatic strategies, and high-impact actions to reduce health disparities among racial and ethnic minorities
- A set of evidence-based approaches designed to achieve large-scale impact, and achieve Secretary Sebelius' strategic goals for the Department
- An HHS commitment to continuously assessing the impact of all policies and programs on racial and ethnic health disparities

HHS Health Disparities Action Plan Builds on Key National Initiatives

- **Healthy People 2020**
- ***Let's Move!* & White House Task Force on Childhood Obesity**
- **HHS Strategy to Reduce Disparities in Influenza Vaccination**

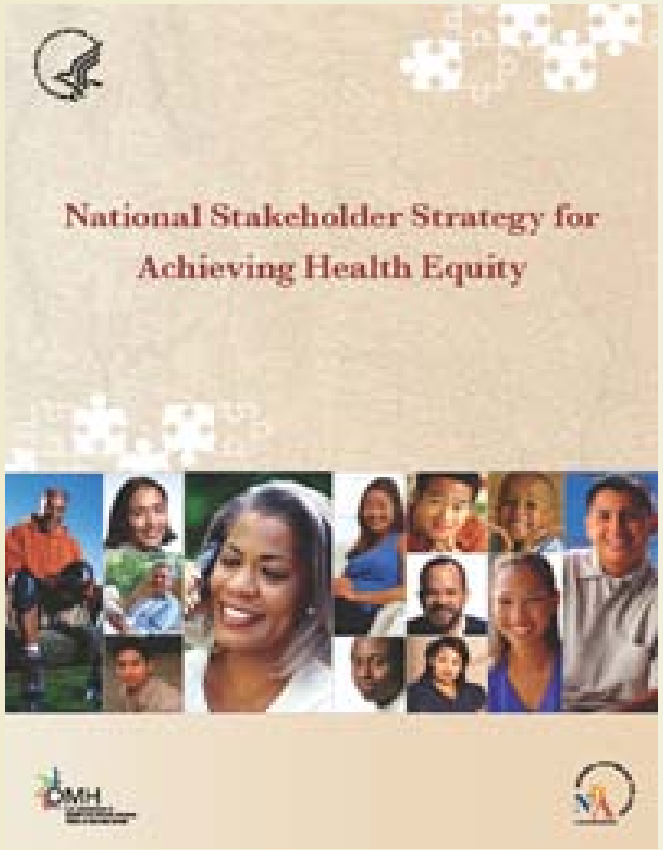






The National Stakeholder Strategy

- **Reflects the commitment of 5,000 individuals across the country in almost every sector, from housing, to education, to health.**
- **Provides 20 strategies supported by action steps for reaching 5 goals.**
- **Guides stakeholders (federal, regional, tribal, state, and local) to adopt the most effective strategies and action steps for their communities.**



Overarching Secretarial Priorities for the Health Disparities Action Plan

1. Assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities.
2. Increase the availability, quality, and use of data to improve the health of minority populations.
3. Measure and provide incentives for better healthcare quality for minority populations.
4. Monitor and evaluate the Department's success in implementing the HHS Disparities Action Plan

HHS Health Disparities Action Plan

Goal 1 Transform Health Care

Goal 2 Strengthen the Nation's Health and Human Services Infrastructure

Goal 3 Advance the Health, Safety, and Well-Being of the America People

Goal 4 Respond to and complement the National Stakeholder Strategy for Achieving Health Equity

Goal 5 Increase Efficiency, Transparency, and Accountability of HHS Programs

Goal I - Transform Health Care

A. Reduce disparities in health insurance coverage and access to care
   - Increase and equalize the number of people with health insurance via Medicaid, CHIP, Medicare, Health Insurance Exchanges, and other forms of health insurance

B. Reduce disparities in access to primary care services and care coordination
   - Increase and equalize the proportion of persons with a usual primary care provider

C. Reduce disparities in the quality of health care
   - Improve the quality of care provided to minorities in the Health Exchanges
   - Increase adoption of electronic health records to improve care for racial and ethnic minority communities through the Regional Extension Centers program

Goal II - Strengthen the Nation's Health and Human Services Workforce

A. **Increase the ability of all health professions and the health care system to identify and address racial and ethnic health disparities**
   - **Support the advancement of translation services**
   - **Enhance Culturally and Linguistically Appropriate Services Standards**

B. **Promote and increase the use of community health workers and Promotoras**

C. **Increase the diversity of the health care and public health workforce**
   - **Increase the diversity and cultural competency of clinicians**
   - **Increase health field training opportunities for recipients of TANF**
   - **Increase the diversity of the HHS workforce**

Goal III - Advance the Health, Safety, and Well-Being of the American People

A. Increase the availability and effectiveness of community-based programs and policies
   - Implement an education and outreach campaign regarding preventive benefits
   - Implement targeted activities to reduce disparities in flu vaccination.

A. Conduct and evaluate pilot tests of health disparity impact assessments of selected proposed national policies and programs.

Goal IV – Advance Scientific Knowledge and Innovation

A. Increase availability and quality of data collected and reported

- Implement a multifaceted health disparities data collection strategy
- Establish data standards and ensure federally supported programs and surveys collect and report data on race, ethnicity, gender, primary language and disability status per Sec. 4302 of the Affordable Care Act

B. Conduct and support research to inform disparities reduction initiatives

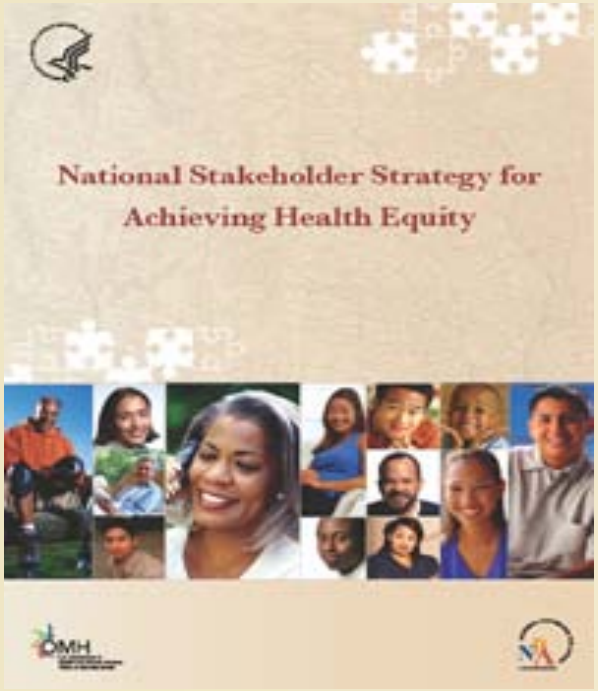
- Collaborative health disparities research results across departments.
- Increase adoption and dissemination of patient-centered outcomes
- Promote community-based participatory research approaches
- Expand research capacity for health disparities research
- Leverage regional variation in search of replicable

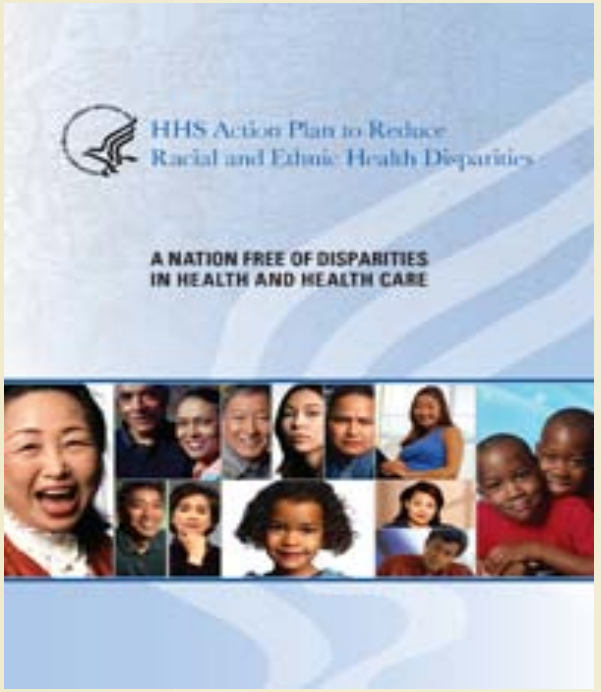
Goal IV – Advance Scientific Knowledge and Innovation

A. Increase the availability and quality of data collected and reported
   - Establish data standards and ensure federally supported programs and surveys collect and report data on race, ethnicity, gender, primary language and disability status per Sec. 4302 of the Affordable Care Act

B. Conduct and support research to inform disparities reduction initiatives
   - NIH will bring together various Federal Departments to promote greater collaboration, utilization, and dissemination of health disparities research results.
   - Develop, implement, and test strategies to increase the adoption and dissemination of patient-centered outcomes research.
   - Leverage regional variation research in search of replicable success in health disparities.

What Brings These Two Together?

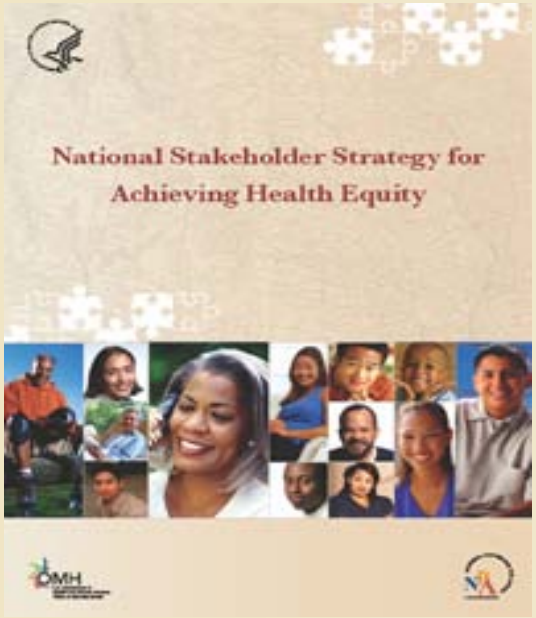




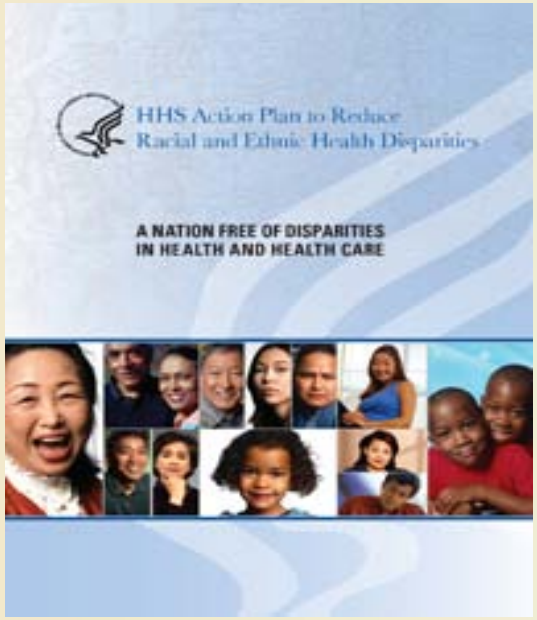
Community Driven

HHS Response

Since these two are intentionally aligned and have common goals, strategies, objectives, actions and performance measures



+



=

PROGRESS

We implement them together!

Implementing the HHS Health Disparities Plan

Role of PCOR

HHS PCOR

- $ 400 Million total funding for CER
  - majority distributed through variety of funding mechanisms
- $2 Million to OMH for PCOR Adoption and Dissemination Initiative
- $7 Million to OMH and NIMHD for Collaboration on CERED Initiative
- Additional funding provided for PCOR initiatives underway at other HHS OpDivs

OMH Patient Centered Care Collaborative (PCCC)

- An adoption and dissemination intervention that engages health care and community partners, community health systems organizations, patients, and providers in identifying, disseminating, and promoting CER to racial and ethnic minorities in the targeted geographic area
- Conducted via Contract mechanism with WESTAT

OMH Patient Centered Care Collaborative

- Identifies priority diseases with high prevalence in racial and ethnic minorities
- Addresses social determinants of health, and the cultural, social factors that contribute to disproportionate outcomes in minority groups
- Requires the engagement of local academic, community and health care experts, and recipients in the planning and conduct of PCCC.

Responds to CER Investment #4

- To increase adoption, dissemination, and use of evidence informed CER among racial and ethnic minorities patients, providers, health care and community health systems.

From Federal Coordinating Council for CER, Report to the President and the Congress, Types of CER Investments, pg. 6.

OMH PCCC CER Initiative: Selected Conditions and Approaches

- Reduce health disparities in **cardiovascular disease and diabetes** through the adoption and dissemination of the following IOM recommended interventions:
  - Clinical and community-based multi-level interventions for enhancing patients adherence to medication regimens;
  - community-based multi level interventions, simple health education, usual care
  - Community health worker interventions

OMH PCCC CER Interventions

- Chicago CER project: Community Health Workers conduct Diabetes Education Program for Diabetes patients at a Community Health Center in Chicago to determine if a clinic based diabetes education program is effective in improving diabetes management and outcomes
- Houston: Pharmacists conduct in home visits and telephone follow up intervention to promote medicine adherence among diabetes and hypertension patients in Houston Public Housing.

OMH PCCC Clinical Measures

- Pharmacists and other CER clinical staff collect clinical data at the start of CER interventions, and various points over duration to determine change and outcome of CER approach:
  - Blood Pressure
  - A1c
  - Weight
  - Adherence to Prescribed Medication
  - Patients
  - Various behavioral measures to determine patient health practices

Healthcare and Health System

- Increase provider knowledge and awareness of CER evidence, and to enhance clinical practices, CER tools and resources will be disseminated to promote adoption and use among health care providers, health systems, community health centers, etc.:
  - Provider Tool Kits
  - Social Media Messaging
  - Iphone APPS, RSS feeds
  - Educational Seminars and APHA Training Institutes
  - Utube Messaging
  - OMHRC Webpage
  - Link to HHS Webpage

Patients and Community Partners

- Increase patient knowledge, skills, and motivation to manage and practice skills and behaviors that improve health and wellness, CER evidence will be disseminated for use and adoption among patients, families, and communities thru:
  - Printed Educational Materials
  - Online Materials
  - Facebook, Utube, and other Social Media Messaging
  - Through health care providers and Health Systems
  - Community Outreach and Home Visiting
  - OMHRC Webpage
  - Link to HHS Webpage

OMH/NIMHD CERED Partnership Initiative

Comparative Effectiveness Research for Eliminating Disparities (CERED)

Other HHS CER

- Comparing the Effectiveness of Traditional Evidence-Based Tobacco Cessation Interventions to Newer and Innovative Interventions Used by Comprehensive Cancer Control Programs
  Increasing Adoption of Early Intervention to Prevent Diabetes After Gestational Diabetes Mellitus
- New Strategies to Disseminate Comparative Effectiveness Research to Patients and Providers
- Dissemination of CER to Physicians, Providers, Patients and Consumers—Regional Dissemination Centers
- Dissemination of CER to Physicians, Providers, Patients and Consumers—Academic Detailing
- Enhancing the Adoption of CER in the Treatment of Serious Mental Illnesses in Medicaid

Office of Minority Health Comparative Effectiveness Research Patient Centered Care Collaboration

OMH PCOR Lead: Jamila R. Rashid, PhD, MPH
Jamila.rashid@hhs.gov
Associate Director for Research and Policy
HHS/Office of Minority Health

NPA PLANS

Both plans available at http://minorityhealth.hhs.gov

HHS Action Plan to Reduce Racial and Ethnic Health Disparities

http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

National Stakeholder Strategy for Achieving Health Equity

http://minorityhealth.hhs.gov/npa/templates/content.aspx?lvl=1&lvlid=33&ID=286

For Additional Information Contact Office of Minority Health at 240-453-2882