

Improving Care and Outcomes of Uninsured Persons with Chronic Disease . . . Now

Chronic disease kills, and uninsured persons with chronic disease are particularly vulnerable to poor outcomes. In this issue, Wilper and colleagues (1) report that an estimated 11.4 million working-age Americans with cardiovascular disease, hypertension, diabetes, hypercholesterolemia, pulmonary disease, and cancer do not have health insurance.

The usual clarion call about the uninsured is to expand access to insurance. Health care insurance reform is necessary for good care for chronic disease, but it will not be sufficient unless it is coupled with quality improvement efforts targeting the reasons that vulnerable populations with access to care often do not receive optimal care. I outline what every practice, every hospital, and every health plan can do now to improve outcomes for vulnerable patients with chronic disease and identify opportunities for policy reforms.

1. *Examine your own performance data, stratified by insurance status, race and ethnicity, language, and socioeconomic status.* Health care is local. Organizations and providers must be convinced that a local problem exists before they will take action. Eighty-eight percent of providers recognize that racial disparities in care exist nationally, but only 40% believe that they are present in their practice (2). Most providers and organizations become disturbed and motivated when they find that their own patients are experiencing disparities in their care. A hard look at one's own data is the first step toward effective action.

2. *Get training for you and your staff to work effectively with diverse populations.* Members of racial or ethnic minority groups are more likely than white persons to perceive that medical staff judge them unfairly or treat them with disrespect and to believe that they would receive better care if they were of a different racial or ethnic group (3). Overt racism by providers, such as a conscious effort by a physician to deny an African American evidence-based care, is probably rare. However, implicit bias—the unconscious perceptions and attitudes we hold toward our patients—may partially explain racial differences in the rates of such procedures as thrombolysis for myocardial infarction (4). State-of-the-art disparities training encourages people to explore the attitudes and biases that providers and patients bring to the clinical encounter. These curricula review causes and solutions for disparities and improve communication skills with such techniques as the teach-back method (“tell me what I just said”) for patients with limited health literacy (5). Everyone can improve their care of uninsured, vulnerable populations. Success depends on self-awareness, the ability to put oneself in another's shoes, and application of concrete communication skills.

3. *Make reduction of inequities in care for vulnerable*

populations an integral component of quality improvement efforts. Quality improvement initiatives could be a powerful way to reduce disparities, but they are often simply another missed opportunity (6). Three themes emerged in the Robert Wood Johnson Foundation *Finding Answers: Disparities Research for Change* Program's systematic review of proven interventions to reduce racial and ethnic disparities in care (7, 8). First, the most successful approaches are multifactorial interventions that address multiple leverage points along a patient's pathway of care. Uninsured patients frequently face multiple barriers, ranging from access to medications to transportation for health care visits. One insuperable barrier can defeat them. Successful quality improvements lower each barrier. Second, to reduce disparities, culturally tailored quality improvement seems more promising than generic quality improvement techniques (9). For example, a management plan is likely to fail if it does not take into account ethnic diets, historical mistrust, employment hours of the working poor, difficulties with transportation, or health literacy levels. Finally, promising nurse-led interventions incorporate multidisciplinary teams and close tracking and monitoring of patients.

4. *Provide models of care and infrastructural support to enable organizations to improve the quality of care for vulnerable patients.* The Health Disparities Collaboratives are an ambitious national effort to improve care for patients in community health centers. On average, 40% of health center patients are uninsured. This relatively simple intervention consists of rapid Plan-Do-Study-Act quality improvement cycles, the MacColl Institute Chronic Care Model, and meetings in which health centers learn these techniques and share best practices. The Collaboratives have improved the quality of care for diabetes, hypertension, and asthma (10, 11).

Why have the Collaboratives worked? First, most health centers adopted this chronic disease quality improvement model because it makes good common sense: If a problem exists, try a solution; if it does not work, revise and try again. Attack the key elements that improve chronic illness outcomes (self-management, evidence-based care, information systems, design of the clinic, health center leadership, and community resources). If someone has figured out a good solution, copy it rather than wasting energy reinventing the wheel. In addition, resources and support are essential. The Health Resources and Services Administration's Bureau of Primary Health Care played a major role in the success of the Health Disparities Collaboratives. It provided training, coaching, and patient registry software. It convened centers to encourage networking. It provided support over many years and convinced health

center leadership that they had to address their disparities in care.

Although providers and health care organizations can do much to reduce disparities, policy reforms are necessary to sustain improvements in outcomes for the uninsured with chronic disease. The next 2 recommendations describe key policy changes.

5. *Align incentives to reward providers and health care organizations for providing high-quality care to vulnerable populations.* Reducing health disparities should be a key measure of the success of any effort at health care reform. Medicare and other payers must collect and report quality measures stratified by race/ethnicity, socioeconomic status, and primary language. They could base reimbursement in part on reduction of disparities. Infrastructural measures may be helpful (for example, a health care organization's cultural competence), but they cannot substitute for improved bottom-line clinical performance. For insured vulnerable populations, pay-for-performance schemes hold both risk and promise (12). Poorly designed pay-for-performance plans can exacerbate disparities. For example, if provider rewards depend solely on reaching an absolute level of performance (for example, receiving a bonus if 90% of patients meet a performance standard), the practice has an incentive to dump vulnerable patients, because it may be harder to get their blood pressure or hemoglobin A_{1c} under control. Also, the rich may get richer, because wealthy practices are more likely to be able to implement quality improvement interventions. Examples of payment schemes that would protect vulnerable populations include rewarding relative improvement as well as absolute performance and providing additional funding to support quality improvement efforts in safety net organizations.

6. *Allocate more resources for uninsured people with chronic disease.* Creating incentives for health care organizations to care for uninsured persons is a more difficult challenge and reflects the perverse problem of reconciling what makes sense for society with what is advantageous for the individual health care organization. For example, the Diabetes Health Disparities Collaborative is cost-effective from a societal perspective, because better care results in fewer diabetic complications and hospitalizations (13). However, most individual providers and clinics do not have financial incentives to care for uninsured or poorly reimbursing patients (14).

Ultimately, we need to provide more resources for care of uninsured persons. Part of the problem is lack of insurance. Even within safety-net community health centers, diabetic patients without insurance receive worse care than those with insurance (15). However, the quality of care is also a function of where you receive care (16). If you are uninsured and depend on the public clinic and hospital systems in Atlanta or Chicago, recent budget cuts have reduced your access to quality health care services (17). Health care reform must reward rather than penalize providers who care for uninsured patients. It must ensure that

adequate resources flow to health care organizations and providers that serve a disproportionate share of vulnerable patients. For example, efforts to create and certify patient-centered medical homes could include a focus on access to care, care coordination, provider-patient communication, and reimbursement reform (18).

The article by Wilper and colleagues (1) tells us that chronic disease is rampant among uninsured persons. Caring for them in the United States is a major challenge, but we can start improving their outcomes now while we press for policies that ensure better access to health care. We must do what we can do.

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