Healthcare Disparities: Where do we go from here?

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President and CEO, Health Centers Detroit

November 7, 2011
Presentation Agenda

- Overview and Drivers: of US Disparities

- Results of a Local Solution with National Implications toward Eliminating Disparities in Access and Health Outcomes:
  - Voices of Detroit Initiative (VODI) Demonstration Project 1999 to 2009

- Next Steps: Decreasing Health Disparities and Improving Population Health using HIT
## U.S. Economic Indicators 2001-08

<table>
<thead>
<tr>
<th>Category</th>
<th>Inauguration Day 2001</th>
<th>Sept 1, 2008</th>
<th>% increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment rate</td>
<td>4.2%</td>
<td>8.0%</td>
<td>100%</td>
</tr>
<tr>
<td>Poverty</td>
<td>32.9 M</td>
<td>37.3 M</td>
<td>13%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>41.2 M</td>
<td>47 M</td>
<td>11%</td>
</tr>
<tr>
<td>Budget Deficit</td>
<td>$281 Billion Surplus</td>
<td>$1.2 Trillion Deficit</td>
<td>500%</td>
</tr>
<tr>
<td>Debt</td>
<td>$5.7 Trillion</td>
<td>$9.7 Trillion</td>
<td>70%</td>
</tr>
<tr>
<td>Federal Spending</td>
<td>$1.9 Trillion</td>
<td>$3.1 Trillion</td>
<td>64%</td>
</tr>
<tr>
<td>Price of Gas</td>
<td>$1.50</td>
<td>$4.00</td>
<td>166%</td>
</tr>
</tbody>
</table>

Historical Length of U.S. Recessions

- Dec 2007 through July 2009: 20 months
- Avg Post-war: 10 months
- 2001: 8 months
- 1990-91: 8 months
- 1981-82: 16 months
- 1980: 6 months
- 1973-75: 16 months
- 1969-70: 11 months

Source: House Fiscal Agency Sept 2009
Over these 8 years how did we get here:

- 3 tax cuts to the Wealthiest 2% ($1.7T),
- Medicare Privitization ($140B),
- Medicare Part D RX plan ($750B),
  - Legislation allows no negotiation on drug pricing
- 3 Wars ($1.4T).

This is what caused our deficits/debt; 8 yrs of spending without control. = $4.0T
Medium Net Worth: Racial Gap

Median Net Worth of Households, 2005 and 2009
in 2009 dollars

<table>
<thead>
<tr>
<th>Year</th>
<th>Race</th>
<th>Net Worth</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>Whites</td>
<td>$113,149</td>
</tr>
<tr>
<td></td>
<td>Hispanics</td>
<td>$6,325</td>
</tr>
<tr>
<td></td>
<td>Blacks</td>
<td>$5,677</td>
</tr>
<tr>
<td>2005</td>
<td>Whites</td>
<td>$134,992</td>
</tr>
<tr>
<td></td>
<td>Hispanics</td>
<td>$18,359</td>
</tr>
<tr>
<td></td>
<td>Blacks</td>
<td>$12,124</td>
</tr>
</tbody>
</table>

Source: Pew Research Center tabulations of Survey of Income and Program Participation data

PEW RESEARCH CENTER
Medium Net Worth: Racial Gap

Percentage Change in Median Net Worth of Households, 2005 to 2009

-16% Whites
-66% Hispanics
-53% Blacks

Source: Pew Research Center tabulations of Survey of Income and Program Participation data
PEW RESEARCH CENTER
U.S. Unemployment rate 2001 to 2011: August 2011 Rate = 9.1%

# Detroit: Unemployment Rate

<table>
<thead>
<tr>
<th>City</th>
<th>Unemployment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detroit</td>
<td>28.9%</td>
</tr>
<tr>
<td><strong>Detroit</strong> (including those who have ceased looking for work)</td>
<td><strong>44.8%</strong></td>
</tr>
</tbody>
</table>

Job Lost: Bush and Obama

Clusterstock Chart of the Day

Jobs Lost In The Bush And Obama Administrations

Thousands of Lost Jobs

Bush Administration

Obama Administration

Source: BLS, 2/5/10; Office of the Speaker
U.S. CEO Earnings as a Multiple of average Workers’ Earning

Source: Crystal Report

<table>
<thead>
<tr>
<th>Year</th>
<th>Multiple</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Worker</td>
<td>1x</td>
</tr>
<tr>
<td>Income</td>
<td></td>
</tr>
<tr>
<td>1974 U.S. CEO</td>
<td>34x</td>
</tr>
<tr>
<td>Income</td>
<td></td>
</tr>
<tr>
<td>1995 U.S. CEO</td>
<td>179x</td>
</tr>
<tr>
<td>Income</td>
<td></td>
</tr>
<tr>
<td>2000 U.S. CEO</td>
<td>300x</td>
</tr>
<tr>
<td>Income</td>
<td></td>
</tr>
<tr>
<td>1995 CEO Income in</td>
<td>21x</td>
</tr>
<tr>
<td>Germany</td>
<td></td>
</tr>
<tr>
<td>1995 CEO Income in</td>
<td>20x</td>
</tr>
<tr>
<td>Japan</td>
<td></td>
</tr>
</tbody>
</table>
Percent of Private Wealth Owned by Wealthiest 1% of the Population

1950 to 1978:
Real Family Income Growth By Quintile (We Grew Together)

Census Bureau, Dept Of Commerce
1979 to 1993:
Real Family Income Growth By Quintile (We Grew Apart)

Census Bureau, Dept Of Commerce
1993 to 2000:
Real Family Income Growth By Quintile (We Grew Together)

Census Bureau, Dept Of Commerce
2001 to 2007:
Real Family Income Growth By Quintile (We Grew Apart)

Census Bureau, Dept Of Commerce
Life Expectancy (yrs.) and Income per Capita for selected Countries and Periods

Source: World Bank, 1993
Association Between Death Rates and Income Inequity

Death Rate

Income Inequity
Poverty Status of Nonelderly by race/Ethnicity, 2009

NOTE: FPL in 2009 was $22,050 for a family of four.
SOURCE: Kaiser Family Foundation Analyses
Premature mortality by race/ethnicity, gender and Income level in the U.S., 1979-89

Average years of potential life lost per person per year

Annual family income (1980 U.S. dollars)

Source: National Longitudinal Mortality Study: Kubzansky et al
US Health Care System:

- US Spends $2.5 Trillion/yr on Healthcare
- 47 Million US citizens without Health insurance
- US spends 60% more than Europe or Canada
- Highest costs and worse health status in developing world
- Year 2000 US Health Care premiums are 8x higher when compared to 2006
- 101,000 die each year attributed to lack of health insurance
- 70% of deaths in the US are due to chronic illnesses (Heart dz, Cancer, Stroke, COPD, Diabetes etc)
MI has more Children without a working parent than 46 other States

Number of Children living in poverty in MI grew by 64% over the last decade (14% lived in poverty in 2000, 18% in 2008, 23% in 2009).

Last weekend (8/12/11-8/14/11) in Detroit: Poorest City in the Union- 19 shootings/7 deaths (43% were adolescents)
MI has more Children without a working parent than 46 other States

Number of Children living in poverty in MI grew by 64% over the last decade (14% lived in poverty in 2000, 18% in 2008, 23% in 2009).

22nd annual Kid Count- Annie E. Casey Foundation

Weekend (8/12/11-8/14/11) in Detroit: Poorest City in the Union- 19 shootings/7 deaths (43% were adolescents)
The Health Resources and Services Administration (HRSA) defines **health disparities** as “population-specific differences in the presence of disease, health outcomes, or access to health care”.

Health disparities refer to gaps in the quality of health and health care across racial and ethnic groups.
Definitions

- **Health disparities** – Significant differences in the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates in a racial or ethnic minority population as compared to the health status of the general population.

- **Health equity** – Absence of systematic disparities in health and its determinants between groups of people at different levels of social advantage / Fair, just distribution of social resources and opportunities needed to achieve well-being.

- **Social determinants** - Social, economic, and environmental factors that contribute to the overall health of individuals and communities.
Evidence of damaging health consequences because of racial and ethnic disparities in health care is overwhelming.

Disparities exist in health status, access to care, quality of care, and health outcomes.

1 in 2 Americans will be member of a racial minority by 2050.

Demographics indicating that people of color suffering effects of health care disparities will rise over next ½ century.
Nonelderly Person of color by State, 2009

U.S. Minority Population = 37% (99 million)

Key Facts on Race, Ethnicity and Health Care in the U.S.

- Racial/ethnic disparities in health persist today even when comparing groups of similar SES. For example, the infant mortality rate for college educated Black women is higher than that for White women with similar education (11.5 vs. 4.2 per 1,000 live births).
- The rate of new AIDS cases in 2003 was 3 times higher among Hispanics and 10 times higher among African Americans than among Whites (26 and 75 per 100,000 vs. 7 per 100,000).
- At least 1 in 3 nonelderly Latinos (36%) and AI/ANs (33%) is uninsured, as compared with 22% of African Americans, 17% of Asian and Pacific Islanders, and 13% of Whites.
- Insurance matters, as evidence by the fact that uninsured adults across racial/ethnic groups are at least twice as likely to go without a doctor visit in the past year.
- Black and Latino adults are less likely to rely on a private physician for their medical care than White adults (62% and 44% vs. 77%).
- African American children have a rate of hospitalization for asthma that is 4 to 5 times higher than the rate for White children (527 per 100,000 vs. 144 per 100,000).
- Disparities in quality of care are not getting smaller. Over time, the gap between Whites and African Americans, Hispanics, Asians, and AI/ANs has either remained the same or worsened for more than half of the core quality measures being tracked.
The Determinants of Health:

- **Social determinants of health**—examples include gender, socioeconomic status, employment status, educational attainment, food security status, availability of housing and transportation, racism, and health system access and quality.

- **Behavioral determinants of health**—examples include patterns of overweight and obesity; exercise norms; and use of illicit drugs, tobacco, or alcohol.

- **Environmental determinants of health**—examples include lead exposure, asthma triggers, workplace safety factors, unsafe or polluted living conditions.

- **Biological and genetic determinants of health**—examples include family history of heart disease and inherited conditions such as hemophilia and cystic fibrosis.
What is Lifestyle?  
The health promotion policy and program debate:

- **Lifestyle:**
  - For some: Consciously chosen personal behavior of individuals as it may relate to health
  
  - For some: *is a composite expression of the social and cultural circumstances that condition and constrain behavior,* not just simply the personal decisions that individuals might make in choosing one behavior over another.
“Of all the forms of inequity, injustice in health care is the most shocking and inhumane”.

Dr. MLK
Federal Strategies to address Health Disparities

- National Quality Strategy 2011
- National Prevention Strategy 2011
- Healthy People 2020
- Office of Minority Health (National Partnership for Action) - National Stakeholders strategy for achieving health equity, April 8th, 2011
- Department of Health and Human Services – Action Plan to reduce racial and ethnic health disparities, April 8th, 2011
- IOM, Future Directions for the National Healthcare Quality and Disparities Reports, 2010
U.S. history reveals two periods of health reform whose efforts specifically sought to correct race-based health disparities.

- In both periods the positive effects on African-American health was dramatic.

- The **first period, 1865 to 1872**, occurred during the nation’s post-civil war reconstruction period.

- Linked to **federal legislation and policy**.

- Lead to the establishment of black medical schools, black hospitals and black clinics throughout the south, given blacks had to be separate.

- These improvements somewhat reduced the alarmingly high death rates among African Americans and improved many health status indicators and outcome parameters.
U.S. history reveals two periods of health reform whose efforts specifically sought to correct race-based health disparities.

The second period of improvement in African American health status which lasted from 1965 to 1975 was an outgrowth of the Civil Rights Movement.

During this time the modern health system made its first real move toward solving the racial health dilemma via judicial and legislative milestones as the

- **1965 Civil Rights Acts**, outlawed racial discrimination in government funded health programs for all people of color,
- **hospital desegregation** occurred, integrating both hospital staffs and patient populations,
- **Medicare and Medicaid** was established which gave huge blocks of African Americans access to healthcare for the first time in their lives,
- the **community and neighborhood health center** movement helped provide needed basic access to primary care for African American communities.

- African American health status improved dramatically in virtually every measurable parameter during this ten-year period.
- However, after 1975, the gains halted and have experienced a continuous decline in health status in comparison to whites.
What would I recommend if I had 5 mins with President:

- The **four** things that I would focus on if I were advising the President on decreasing broad social disparities in the U.S.:
  1. *Education (first and foremost)*
  2. *Health Care*
  3. *Job Training*
  4. *Criminal Justice System*

- Health and Social Economic disparities are chronic and growing.
  - It is not because of an absence of knowledge of what to do.

- We need to tackle this problem in a concrete ways with concrete resources, not continue to have academic discussions, or we will be talking about significant disparities in the next 50 years.

- What is the current systemic intervention that we are implementing to change the trajectory of U.S. Disparities?
  - It will not happen spontaneously, requires an active process.
  - This issue is the equivalent to a US cancer and it will ultimately destroy us as a nation if we do not solve this issue. Failure leads to significant negative long term social & economic consequences for our country.
Reasons for Health Disparities

- Poverty (34% vs 9%)
- Culture/Behavior
- Health Care System
  - Access
  - Quality
- Discrimination/Bias
- Environment/Genetics
Solutions to Health Disparities

- Improved Educational System
- Economic Revitalization
- Increase/Promote Access To Care
  - Funding Mechanisms: Insurance
  - Health Care Delivery System Restructuring
    - Access to Primary Care/Prevention is the Key
- Health Education
  - Community
  - Providers
  - Patients
- Research into Environmental/Genetic Risk
US Education Stats: 2010

- **U.S. K-12 Public Education:**
  - 50 million children
  - 3 million teachers
  - 150,000 schools
  - Spend $650 Billion nationally

- **Comparing US High School Students among 30 Developed Nations**
  - **1970** US ranked #1,
  - **2010** US students ranked #24-math; 17th Science; 10th reading.
  - 68% of 8th graders can not read at grade level
  - 68.8% of US students graduate from High School each year
    - AA: 54%, Latino: 56%, Low Income students: 55-60%
  - 1 million children drop out from school to the street each year
  - US with a 25% drop out rate.

- We as a Country are willing to disinvest in education as we compete world wide with China, Brazil, India, the EU who are investing and prioritizing education.
  - Decreasing investment and not a priority to educate all of our kids any longer

*Source: National Center for Education Statistics; Education Week and the EPE Research Center 2010.*
Shifting US Health Care System:

The shift in US Health System is occurring:

- A shift in focus from treating disease to sustaining health.
- From solving isolated problems to creating a preferred future.
- From an individual’s needs to a broader perspective on the health of populations.
- A strategy from treating illness to promoting prevention.
- From being reactive to being proactive.

Competencies that made us successful yesterday are not necessarily enough to make us successful tomorrow.

- Changes in the political system, health system, Technology, Increasing complex societal problems:

Assumption:

- Addressing the health needs of an increasingly diverse citizenry can only be done with multisector, multidisciplinary partnerships and coalitions, coupled with increased awareness, personal responsibility to decrease risk for a preventable disease.
The Largest source of our deficits is the rising cost of health care.

Healthcare costs are driving or expanding both our GDP gap and our Federal, State and local budget gaps.

“Rep say: We need to focus on jobs and the economy, not Healthcare”.

Health care is a jobs issue.

58% of Small businesses surveyed in 2008 say they did not give employee raises because of high healthcare costs.

30% of Large businesses are saying that they are going have lay offs because of HC costs.

Therefore Putting America on a sustainable fiscal course will require addressing health care
US Health Care System:

Why is any of this important?

Two core questions:

1. Can we:
   - Cover everyone (universal coverage),
   - Control costs and
   - Provide Affordable HI at the same time, and
   - improve and organize the Delivery system
   - such that we Improve Health Status and Health outcomes?

   - **YES but not with the status quo.** Premiums increasing too fast, 8x faster than earnings, and providing less and less coverage-unsustainable.

   - **Status Quo:** Over the next 7 years HC premiums would go from $13k/yr to $25K/yr, HC costs would drive the loss of 3.5 million jobs (with more uninsured), and the cost to business would double by $1 Trillion dollars by doing nothing making America much less competitive globally.

2. The insured are asking by covering everyone what is the impact on me (84% of Americans have HI, 16% do not).
   - You are already covering the uninsured. The insured subsidize the cost of care for the uninsured currently by $1,200 to $2,000/premium.
   - the underinsured rates have nearly tripled since 2003.
US Health Care System:

Remember the current problem is the unaffordability of health insurance because of no price controls on Insurance premiums.
Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2003

Notes: Data on premium increases reflect the cost of health insurance premiums for a family of four. *

^ Estimate is statistically different from the previous year shown at p<0.1: 2002-2003.

10 Largest US Health Insurance Co. Profits Soar (428%) while number of US Uninsured Rise (30%): FY2000-07

**Profits**

<table>
<thead>
<tr>
<th>Year</th>
<th>Billions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>$2.4 B</td>
</tr>
<tr>
<td>2007</td>
<td>$12.7 B</td>
</tr>
</tbody>
</table>

**# U.S. Uninsured**

<table>
<thead>
<tr>
<th>Year</th>
<th>Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>35.4 M</td>
</tr>
<tr>
<td>2007</td>
<td>45.7 M</td>
</tr>
</tbody>
</table>

Source: US Securities & Exchange Commission (SEC) Filings

Source: US Census Bureau
Reasons for Increasing Growth In Uninsured

• Downturn in the economy with increasing unemployment and decrease in employer-sponsored health insurance
  • Rising health care costs/premium costs
  • Fiscal constraints on public health insurance coverage
Uninsured Projected to Rise to 61 Million by 2020
Not Counting Underinsured or Part-Year Uninsured

Number of uninsured, in millions

Projected Lewin estimates

Projections to 2020 based on estimates by The Lewin Group.
FOR IMMEDIATE RELEASE: THURSDAY, SEPT. 16, 2010

Summary of Key Findings

Real median household income in the United States in 2009 was $49,777, not statistically different from the 2008 median.

The nation's official poverty rate in 2009 was 14.3 percent, up from 13.2 percent in 2008.

There were 43.6 million people in poverty in 2009, up from 39.8 million in 2008 — the third consecutive annual increase.

The number of people without health insurance coverage rose from 46.3 million in 2008 to 50.7 million in 2009, while the percentage increased from 15.4 percent to 16.7 percent over the same period.

Source: *Income, Poverty, and Health Insurance Coverage in the United States: 2009*. The following results for the nation were compiled from information collected in the 2010 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC)
**FOR IMMEDIATE RELEASE: THURSDAY, SEPT. 16, 2010**

**Summary of Key Findings**

<table>
<thead>
<tr>
<th>Year</th>
<th>Poverty</th>
<th>Median Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>11%</td>
<td>$53,000</td>
</tr>
<tr>
<td>2010</td>
<td>15%</td>
<td>$49,000</td>
</tr>
</tbody>
</table>

Source: *Income, Poverty, and Health Insurance Coverage in the United States: 2009*. The following results for the nation were compiled from information collected in the 2010 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC)
Defining **Socialized Medicine** and **Single Payer**
(Government Financed and No Involvement in Care Delivery)

Socialized Medicine

- **Gov. Financed only**
  - Medicare
  - Medicaid
  - TriCare
  - Public Hosp
  - FQHCs

- **Gov. owned/operated/employ health providers & staff**
  - VA
  - US Military Med Dept

**Gov Financed/No Involvement in Care Delivery**

**Gov Financed/Own & Operate Care Delivery**

Any system of medical care that is gov/publicly financed and/or gov admin
According to CMS Report published 2/24/09 in the Journal Health Affairs:

CMS projects:
- Overall U.S. health care spending will reach **$2.5 trillion in 2009** (17.6% of GDP)
  - marking the largest one-year increase since CMS began tracking health care spending in 1960
- was **$2.38 trillion in 2008** (16.6% of GDP)
- was **$2.24 trillion in 2007**
- will reach **$4.35 trillion in 2018**, (accounting for 20.3% of the GDP)

The CMS found that in 2009,
- government health care spending is expected to equal **$1.19 trillion (47.6%)**
- private health care spending is expected to equal **$1.32 trillion**

The study estimates that health care costs will average:
- **$8,160** per U.S. resident in 2009,
- **$13,100** per U.S. resident by 2018

CMS forecasts that the government will pay:
- more than **50%** of total health care spending by 2016 and
- **51.3%** by 2018, as Medicaid enrollment increases and baby boomers start enrolling in Medicare
Health Care Reform

Key Components of Health Care Reform

- Health Insurance Reform
- Coverage expansion
  - MiHealth Marketplace
    (formally called the Health Insurance Exchange)
- Medicaid expansion
- Quality improvement
## Snapshot of major spending and revenue components HCR (2010–2019)

<table>
<thead>
<tr>
<th>Spending Increases</th>
<th>(Billions)</th>
<th>Medicare cuts/Tax Increases</th>
<th>(Billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HC Exchanges subsidies/tax credits 133-400% FPL</td>
<td>$464</td>
<td>Medicare cuts</td>
<td>$500</td>
</tr>
<tr>
<td>Expansion Medicaid to 133% FPL and children’s coverage expansion</td>
<td>$434</td>
<td>Increased Medicare payroll taxes ($200K/$250K)</td>
<td>$210</td>
</tr>
<tr>
<td>Small employer tax credits</td>
<td>$40</td>
<td>Taxes on insurers/drug Manufacturers/medical device sales</td>
<td>$118</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employers (penalties, high-cost plans, Part D deduction)</td>
<td>$90</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other tax increases</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$938</strong></td>
<td><strong>Total</strong></td>
<td><strong>$1068</strong></td>
</tr>
</tbody>
</table>

Source: Ernst and Young/MI Senate Fiscal Agency April 27th, 2010
Health Care Reform

- Medicaid Eligibility expanded to 133% of FPL
  - Single: $14,484
  - Family of 2: $19,564
  - Family of 3: $24,645
  - Family of 4: $29,726

- MIHEALTHMARKETPLACE covers individuals and families with incomes 133% to 400% income levels:
  - Single: $43,520
  - Family of 2: $58,840
  - Family of 3: $74,120
  - Family of 4: $89,400
Health Care Reform Effects on Coverage

Source: Congressional Budget Office (March 20, 2010)
The Ryan plan: The Path to Prosperity

- Cuts $389 billion dollars from Medicare over ten years.
- Defunds Medicaid by $735 billion dollars over ten years.
  - Ends Medicaid as we know it, and replaces it with state block grants with no restrictions on how $$ spent.
- 1 out of 3 Americans are on Medicare, Medicaid, and SCHIP
- Cuts discretionary domestic spending by $923 billion dollars.
- Decreases corporate tax rates from 35% to 25%
- Cuts Pell grants for students.
- Increases the age for Medicare eligibility to age 67 by 2032.
- Caps discretionary spending at less than 20% of GDP.
- Decreases taxes on the top wealthiest 2% of Americans.
  - Does not touch tax entitlements, just spending entitlements
    - Does not eliminate tax breaks for oil, mining, agriculture, banking, off shore companies.
- Two-thirds of the budget cuts of the Ryan plan come from low to middle income people and will therefore only further widen social and economic disparities in the U.S.
**Rep. Paul Ryan’s Deficit Reduction Plan:**
Much Smaller Than Claimed In Trillions of Dollars ($155 Billion in total Deficit Reduction over 10 years)

Source: CBO 2011

### In Trillions of Dollars Over 10 Yrs

<table>
<thead>
<tr>
<th></th>
<th>Spending Cuts</th>
<th>Deficit Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tax Cuts</strong></td>
<td>4.2</td>
<td>-0.155</td>
</tr>
<tr>
<td><strong>Spending Cuts:</strong></td>
<td><strong>Ryan's Plan</strong></td>
<td><strong>Real Impact</strong></td>
</tr>
<tr>
<td></td>
<td>-5.8</td>
<td>-4.3</td>
</tr>
<tr>
<td><strong>Deficit Spending:</strong></td>
<td>-1.6</td>
<td></td>
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</tbody>
</table>

Source: CBO 2011
Solution Toward Change:
W. K. Kellogg National Community Voices Initiative:
Voices of Detroit Initiative (VODI)
Detroit Wayne County Challenges:

- Rising uninsured, rising uncompensated costs ($400M annually), Uninsured with 25% higher mortality rate
- Since FY2000 # on State Medicaid increased by 40%, with 60% rise in GF expense
- 60% decline in Detroit’s primary care physicians capacity
- Significantly higher rates of rising chronic illness in Detroit which, if not effectively managed in a Primary Care setting,
  - results in higher ED utilization and
  - a 69% higher preventable hospitalization rate compared to the rest of the State and
  - therefore higher healthcare costs.

Continuing to do things the same way is not sustainable........
Preventable Hospitalizations

- More common in Detroit than in Michigan
  - 404/10,000 vs 240/10,000 (69% more)

- Conditions with greatest difference:
  - Asthma: 50/10,000 vs 18/10,000 (174% more)
  - Diabetes: 25/10,000 vs 11/10,000 (132% more)
Our Challenge:
Uncompensated Care for Detroit Health Systems = $400 million Annually

No public hospital or public funding mechanism
Needed a Sustainable Care Model

- Cunningham and Kemper found that the ability of the uninsured to access needed medical care is subject to variation in the way that safety net services are organized and delivered.

- According to the Committee on the Consequences of Uninsurance (IOM 2002): Having a regular source of care:
  - improves the utilization of ambulatory care services,
  - encourages the receipt of preventative services
  - and the management of chronic conditions,
  - and reduces emergency room visits and preventable hospitalizations.

- Most uninsured do not know where to get affordable care in their local community.

- The Kaiser Commission on Medicaid and the Uninsured has reported that 47% of the uninsured delay seeking care because of prohibitive costs.
Detroit’s Response.. How Did We Get Here?

- 1998 Kellogg Foundation funded 13 cities out of 80 who applied: $5 million grant over 5 years.
  - The Kellogg Foundation’s *Community Voices* grant initiative sought to achieve **five** outcomes toward the development of a Care Model for the uninsured:
    - Sustained increases in access to care for vulnerable and uninsured populations
    - Strengthening of the community safety net through community-driven change and community partnerships
    - Building of cost-effective and high-quality delivery systems
    - Model should provide system change and be sustainable beyond the 5 year grant funding.
    - Development of best practices that could be shared with other communities
W. K. Kellogg National Community Voices Consortium: $65 million Project Nationally

- List of the 13 National Community Voices Projects
  1. Albuquerque, NM
  2. Baltimore, MD
  3. Charleston, WV
  4. Denver, CO
  5. Detroit, MI: **Voices of Detroit Initiative (VODI)**
  6. El Paso, TX
  7. Lansing, MI
  8. Miami, FL
  9. Northern Manhatten, NY
  10. Oakland, CA,
  11. Pinehurst, NC
  12. Sacramento, CA
  13. Washington, DC
VODI: Who We Are …The Detroit Wayne County Consortium: Collaborating around the uninsured

Voices of Detroit Initiative is a collaborative partnership between:
- City of Detroit Health Department,
- Wayne County Health Department
- Henry Ford Health System,
- St. John Health System,
- Detroit Medical Center,
- Oakwood Health System
- Wayne State University School of Medicine
- 6 Federally Qualified Health Centers (FQHCs): CHASS*, Detroit Community Health Connection*, Advantage Health Care**, Health Centers Detroit, Wellness, Western Wayne **
- Detroit Wayne County Health Authority
- Free Clinics
- Community Advisory Committee

** VODI Assisted in 3 new FQHC Org (7 new PC sites) + *an additional 4 new access sites for existing FQHCs being approved since its inception in 1998, totaling 11 new PC access points (started with 3 FQHC & 6 sites ended with 6 FQHC and 17 sites).
VODI Objective:

- Providing leadership that helps organize care delivery and expand and improve access to cost-effective, high quality health care, for the uninsured and underserved.
  - Provider Network that directly gets people Care/Medical Home
  - Seamless integration of the full continuum of care for the uninsured and underserved
    - *People with fragmented lives do not do well in a fragmented healthcare delivery system* - H. Smitherman MD, MPH
An Overview of the VODI Project: A Path to Reform

- The VODI Question:
  - Could we transition adults (age 18 to 64) without health insurance out of the ER to Primary care settings by providing them:
    - Active ER>>PC Intervention
    - health care coverage,
    - organized delivery system, and
    - care/disease management?
The VODI Intervention Model (VIM):

- Detroit providers agreed to provide care to:
  - 27,500 uninsured Detroiters (13.75% of the Det uninsured pop)

- **Kellogg Grant** $$ paid for no care, only infrastructure

- **Intervention:** ER enrollment + Case and care management linked to PCP/Medical Homes

- **VODI providers** provided Primary care at no or significantly reduced cost
  - Commitment for the full continuum of care
  - ED Diversion Strategy = significant cost savings
  - Demonstrate the value of managing care of the uninsured.

- **VIM** is an active outreach in ERs>>>PC sites
  - Enrollment/Registration/tracking/utilization data analysis
  - Primary Care Medical Home assignment, appt & **use** + Case Mgt
Characteristics of VODI (uninsured) Population

- 57% women: 43% men
- Age 18 to 64
- 69% Single
- 92.4% African-American
- 64% with total household income less than $1000/month
- 56.7% employed vs. nationally 83% employed
  - Only 20% of the VODI Enrollees earned more than $8/hr.
  - Average annual income: $10,851
- 53% with 3 or more people in household
- 36% with chronic condition

Summary: Single, AA women, less employed, poor, sicker, supporting multiple family members
Active ER enrollees whose:

- First encounter after enrollment was in a Primary Care setting: 39.4%
- Second and later encounters after enrollment was in a Primary Care setting: 15%
- **VODI Outcome Summary:** Transferred a Total of 55% of Active Enrollees out of ER into Primary Care Settings with a 42% costs savings.
## VODI Outcome

### Ten Year History of VODI Enrollment

#### Number of VODI Clients Enrolled in VODI (uninsured) Program or Medicaid /ABW 1999-2009

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<th>Enrollment Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>Sub-Total 1999-2004</th>
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<td>PlusCare/ABW Medicaid application filed</td>
<td>0</td>
<td>0.0</td>
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<td>52.1</td>
<td>2,510</td>
<td>41.1</td>
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<td>6,113</td>
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<td>8,585</td>
<td>16,070</td>
<td>20,690</td>
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<td>98</td>
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<td>Est. Number of Uninsured Det/Wayne</td>
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Home Page

Welcome to the VODI Books website

Voices of Detroit Initiative (VODI) is proud to present

- Books for Sale
- Authors that have written books for VODI
- News & Updates from VODIBooks.org

Release event for "Taking Care of the Uninsured : A Path to Reform"

- Friday, December 14th, 2007
- Read more about it click here
VODI Intervention Model: Summary

- Demonstrated and Documented Effectiveness of VODI Care Model
- Transitioned 55% of Active Enrollees out of ERs to Primary Care Setting
- Resulted in a 42% Rev/Cost Savings
- Facilitated Primary Care Access for 71,578 uninsured
- Reduced avoidable ED visits and inpatient stays for Uninsured and Medicaid and reduces costs.
- Showed Primary Care as the vital link in organizing care
- Promoting VODI Model Nationally with the Funding Support of Kellogg Foundation
- In addition to Funding it (Universal Health Care) we must also Fix it (Organize the Delivery System)
- Next step: IT services and Integration
The SEM Beacon Award

- **HITECH Act:**

  The *Health Information Technology for Economic and Clinical Health* (HITECH) Act,

  - **Enacted** as part of the *American Recovery and Reinvestment Act of 2009*, was signed into law on February 17, 2009, *to promote the adoption and meaningful use of health information technology.*

  - **Created:** The *Office of the National Coordinator for Health Information Technology* (The ONC)

  - HIT is Critical to addressing U.S. Health Disparities
ARRA-HITECH Funding Total = $1.7 B

- Regional Extension Centers $677 M
- State Health Information Exchange $564 M
- Workforce Training Programs $118 M
- **Beacon Communities** $265 M
- NHIN $64 M (National Health Information Network)
- SHARP $60 M (Strategic HIT Advanced Research Projects)
The HITECH Vision

Regional Extension Centers
Workforce Training
Medicare and Medicaid Incentives and Penalties
State Grants for Health Information Exchange
Standards and Certification Framework
Privacy and Security Framework

Adoption of EHRs
Meaningful Use of EHRs
Exchange of Health Information

Research to Enhance HIT

Improved Individual and Population Health Outcomes
Increased Transparency and Efficiency
Improved Ability to Study and Improved Care Delivery
The Value Proposition: Provides a single source of clinical records; collects, integrates, normalizes, and standardizes data; a secure source of a virtual Pt. record; assembles information so providers can identify and prioritize health concerns; improves chronic disease mgmt & preventive health; clinical transformation; improves patient outcomes and creates healthy communities.
It is About Collaboration, And Mobilizing Community Partnerships

THE END (The Beginning)

Detroit