

Across America, there is a high burden of chronic diseases, such as diabetes, obesity, stroke and heart disease. In fact, 60 percent of Americans have at least one chronic disease and 42 percent have multiple chronic conditions, resulting in substantial morbidity, mortality and disability.¹ As a result, 90 percent of health expenditures in the United States are for people with chronic and mental health conditions.² In addition, chronic disease prevalence is higher among older adults, with 81 percent of adults 65 years or older experiencing at least one chronic disease.³

We also see disparities in chronic disease burden – and how well those diseases are managed – across populations. Racial and ethnic minorities face higher rates of chronic diseases, which also vary by where people live.⁴

Yet, these disparities are not solely about racial/ethnic background or access to care. An emerging body of research shows that health care services only account for a fraction of what determines a person's overall health: approximately 80 percent of health outcomes are accounted for by factors outside of medical care. Physical environment, social determinants and behavioral factors play a dominant role in determining health outcomes. Social determinants of health – the conditions in which people are born, grow, live, work and age – manifest themselves through factors such as food security, transportation, housing, social isolation and safety, and are crucial to individual and community health and well-being. Analyses of life expectancies across the U.S. demonstrate that where a person lives has a dramatic impact on their life expectancy.⁵

Visualizing health disparities through maps can help identify where disparities exist and what populations are most vulnerable. While some generalizations can be made, it is important to understand exactly where health disparities are occurring at a local level. Maps

allow health care leaders to tell the story of who is experiencing disparate health in the community as well as inform policy decisions and target interventions.

Mapping Medicare Disparities

A recent tool from the Centers for Medicare & Medicaid Services (CMS) provides an interactive map to explore geographic disparities among Medicare beneficiaries related to health outcomes, utilization and spending. The agency's Mapping Medicare Disparities tool allows users to:

- Visualize health outcomes at a national, state or county level;
- Identify health outcomes by patient characteristics;
- Compare differences between geographic locations; and
- Compare differences between racial and ethnic groups.

The tool allows users to explore disparities by population or hospital.

How Hospitals and Health Systems Can Use the Mapping Medicare Disparities Tool

The Mapping Medicare Disparities tool shines light on disparities in health outcomes and quality of care in the Medicare population that hospitals and health systems can use to guide future strategies. The tool has potential widespread use by members of the hospital team:

- **Quality Improvement Leaders.** Use this tool to augment your hospital's data disparities in health care quality. It will allow you to better understand which populations are receiving lower quality care, so that you can work with care teams to develop new processes to address disparities.
- **Health Equity Leaders.** Use this tool to describe the nature and scope of disparities in your community. This data can help you build out your

hospital's strategic plan to promote health equity, identify patients and communities to engage and benchmark progress over time. You also can use this data to see how your hospital and community compare with others in your region.

- **Community Benefit Leaders.** Use this tool as you develop your hospital's community health needs assessment to show the health status and disparities of the 65+ population at your hospital and within your footprint. If your hospital chooses to prioritize health disparities or issues facing the elderly population, this tool can help focus your strategy and programs on the most vulnerable populations.

Considerations for Use

The Mapping Medicare Disparities tool provides relevant data to guide strategies and interventions; however, there are some considerations to keep in mind as you use it:

1. This tool uses data from Medicare beneficiaries 65 years and older and the findings may not be applicable to the entire population.
2. This community-level data should not substitute for examining your own patient, community and neighborhood data for disparities beyond the Medicare population.
3. The data come from CMS administrative enrollment and claims, so risk adjustment is unknown.

Access the Mapping Medicare Disparities tool at:

www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities.html.

Sources

1. Buttorff C, Ruder T, Bauman M. Multiple Chronic Conditions in the United States. Santa Monica, CA: Rand Corp.; 2017.
2. Centers for Medicare & Medicaid Services. National Health Expenditure Data for 2016—Highlights.
3. Buttorff C, Ruder T, Bauman M. Multiple Chronic Conditions in the United States. Santa Monica, CA: Rand Corp.; 2017.
4. Centers for Disease Control and Prevention. *Racial and Ethnic Approach to Community Health*.
5. Virginia Commonwealth University, Center on Society and Health. 2016. *Mapping Life Expectancy*.

AHA Resources

Explore AHA resources and toolkit that can support your work reducing health disparities.

- **[Connecting the Dots: Value and Health Equity](#)**. Learn about the connection between value and health equity and what hospitals are doing to address it in this [issue brief](#) from [The Value Initiative](#).
- **[Mapping Medicare Disparities Webinar](#)**. [Learn more](#) about how to use the Mapping Medicare Disparities tool from CMS and HRET's Health Improvement and Innovation Network.
- **[CHNAFinder](#)**. Explore trends in [Community Health Needs Assessment priorities](#) across the country. Filter by state, region or community health issue to find what other hospitals are working on.
- **[Social Determinants Issue Briefs and Presentation Deck](#)**. Learn about what hospitals and health systems can do to address the [social determinants of health](#). Teach your colleagues and community about social determinants of health using this [slide deck](#).
- **[#123forEquity Pledge](#)**. Take the [pledge](#) to reduce health disparities in your community by: 1) increasing the collection and use of race, ethnicity and language preferences; 2) increase cultural competency training; 3) advance diversity in leadership and governance; and 4) strengthen community partnerships.