

to design an educational intervention to equip clinicians with skills to mitigate implicit bias without inducing defensiveness is unclear. COMmuNity-engaged SimULation Training for Blood Pressure Control (CONSULT-BP) Trial is a 5-year clinical trial educational intervention designed in collaboration with racial, ethnic, and socioeconomically diverse representatives of the local patient community. CONSULT evaluates clinician trainee awareness of and defensiveness about implicit bias pre- and postexposure to a face-to-face simulation training with standardized patients (SPs) from local racial and ethnic communities.

Study Design: Pre-post analysis of trainee bias awareness and defensiveness in the context of a clinical trial that evaluates the impact of an educational intervention to improve clinicians' interaction skills with diverse populations. Participants completed two, in-person educational sessions, 5 weeks apart. Learning components included the following: online modules on health disparities, implicit bias, and patient-centered care; and face-to-face simulation encounters with diverse SPs. Four Implicit Association Tests (IATs) were used to measure implicit and explicit bias, and to promote self-reflection. We measured pre/post bias awareness using a 7-item Bias Awareness Scale and defensiveness using a 3-item pre/post measure of reaction to feedback on implicit bias scores. We also collected trainee feedback about the educational experience.

Population Studied: Graduate medical and nurse practitioner trainees, including internal medicine, family medicine residents, and nurse practitioner students. We present preliminary findings from CONSULT year 1 cohort ($N = 86$).

Principal Findings: Both before and after, the intervention participants slightly agreed that they are objective that bias does not affect their decision-making, disagreed that society treats all groups equally, and that all people have equal opportunity. After the intervention, participants were significantly more likely to disagree with the statement that bias is no longer a problem in patient care ($P = 0.00$). In response to feedback on their IAT scores, participants were more likely to agree that the IAT reflects "something about my thoughts or feelings, unconscious or otherwise" (48% pre, 54% post). Preintervention, 76% agreed that "the IAT captures something important about me" but only 58% agreed postintervention. When asked if the IAT reflects something about their "automatic thoughts and feelings" concerning racial/ethnic bias, 75% agreed preintervention and 65% agreed postintervention. Qualitative feedback from trainees reported that the intervention was a burden on their, taking numerous IATs was redundant, and identified an unmet need to address patient bias toward medical providers.

Conclusions: Defensiveness about implicit bias scores increased after exposure to our educational program to mitigate implicit bias. Trainees identified challenges with our educational approach and study design.

Implications for Policy or Practice: We learned of the need to include trainee participants during the design phase of this type of training experience and refined our educational intervention for subsequent cohorts. Without sacrificing essential elements of education, investigators amended the study for years 2-5 to a single session, one

IAT per participant, streamlined content in educational modules and included more in-person education by an educator with the experience and skills needed to facilitate discussion on this highly charged and complicated topic.

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Patient and System Factors Associated with Racial and Ethnic Disparities in Ambulatory Care Among Medicaid-Enrolled Adults with Intellectual and Developmental Disabilities

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Research Objective: Persons with intellectual and developmental disabilities (IDD) have complex medical needs and experience gaps in care due to their unique needs, and challenges faced by health professionals in responding to them. We characterize New Jersey Medicaid-enrolled individuals with IDD and examine racial and ethnic (RE) disparities in ambulatory care (AC) quality and the extent to which RE gaps are explained by patient and health system factors. We focus on the potential positive effect of home and community-based services (HCBS) provided through Medicaid waiver programs in mitigating disparities and improving care.

Study Design: Utilizing New Jersey Medicaid comprehensive claims data over 2011-2017, quality of AC was assessed using AC sensitive preventable hospitalizations (PH), IDD-specific PH (IDDPH), and ED visits. Additional metrics including rates of preventive care visits (cancer screening, vaccination) and quality of behavioral health (BH) care will be available by the time of the conference. Econometric modeling of disparities utilized the Institute of Medicine as well as the Residual Direct Effect approaches that adjust for patient characteristics (sex, age, number of chronic and IDD conditions, presence of BH condition), allowing for mediation of disparities through provider and system-level factors, for example, average quality of AC in zip code of residence. Difference-in-difference estimation examined how availability of HCBS waiver services impacted differences in quality across racial/ethnic groups. Findings from analysis utilizing an area-level instrumental variable addressing potential selection into waiver services and access to IDD-specialized providers will be available for the conference. Statistical significance was assessed at $P = .05$ threshold.

Population Studied: 37 078 Medicaid-enrolled individuals of age 22+ over 2011-2017, who reside: a) in DD intermediate care facilities, or b) in the community and receive HCBS from waiver programs, or c) in the community, do not receive Medicaid-paid HCBS and diagnosed with one or more of 13 IDD conditions. We examined ambulatory

care among 92.7% of this population ($n = 34\,382$) who were always in the community.

Principal Findings: 44.2% of the community population was female, the mean age was 45.5 years, 59.3% had a BH condition, 25.6% had 3+ chronic conditions, and 49.4% were enrolled in HCBS waivers that provide services such as case management, day habilitation, and assistive technology. Among them, black (OR = 0.55) and Hispanic (OR = 0.21) populations had lower adjusted odds of being enrolled in waivers providing HCBS. Among those not receiving Medicaid-paid HCBS, blacks had higher odds of PH (OR = 1.50), ED visits (OR = 1.33), and IDDPH (OR = 1.11). Hispanics had higher odds of ED visits (OR = 1.12). However, these disparities did not exist for individuals enrolled in HCBS waiver programs.

Conclusions: Our analysis sheds light on RE disparities in AC outcomes within the IDD population using established measures of care quality and identifies several mechanisms associated with such disparities. We found a positive effect of HCBS on these outcomes in mitigating such disparities.

Implications for Policy or Practice: These findings underscore the beneficial role played by state waivers in ensuring provision of HCBS to individuals with IDD and, additionally, may guide formulation of performance metrics within Medicaid managed care contracts, and guidelines for health professionals offering specific IDD and medical services.

Primary Funding Source: Agency for Healthcare Research and Quality.

Assessing Racial-, Ethnic-, and Socioeconomic-Disparities in Access to High-Quality Home Health Agencies

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Research Objective: Prior research indicates that neighborhoods with predominantly minority and low-income individuals have decreased access to high-quality hospitals, primary care physicians, and nursing homes. Research in the home health (HH) setting reports that blacks and Medicare/Medicaid dually eligible beneficiaries are less likely to receive care from 4- and 5-star rated HH Agencies (HHAs) and more likely to receive care from lower- and unrated HHAs. We know very little about why this is. One possible explanation could be that the available choices for minorities and low-income older adults are only lower quality HHAs. The objective of this study is to document the availability of high-quality HHAs across neighborhoods. We hypothesize that neighborhoods that have a larger proportion of racial and ethnic minorities, and low-income individuals, will have fewer high-quality (4- and 5-star) HHAs available.

Study Design: A national descriptive study using 2017 Census data linked with HHCompare Star Rating and Agency Service Area. We characterize neighborhoods (defined by ZIP Code Tabulation Areas)

by racial and ethnic composition and the proportion of residents below the federal poverty line (FPL). Neighborhoods with greater than 60% of one race were coded as predominately black, Hispanic, minority, or white; otherwise, the neighborhood was listed as integrated. Poor neighborhoods were those with 20% of their population below 200% of the FPL.

Population Studied: All neighborhoods ($n = 31\,620$) served by Medicare-certified HHAs.

Principal Findings: On average, there are more HHAs per one thousand older adults available in predominantly minority communities than in white and communities. Black neighborhoods have an average of 57 HHAs, 45 HHAs in Hispanic neighborhoods, and 31 HHAs in white neighborhoods per one thousand older adults. Predominately minority neighborhoods are served by the highest proportion of unrated HHAs. 11% of the HHAs in black neighborhoods are unrated, as compared to 8% in Hispanic neighborhoods and 5% in predominately white neighborhoods. 29% of HHAs in black neighborhoods and 35% in Hispanic neighborhoods are low quality (1-2.5 stars) as compared to 22% in white neighborhoods. Over 33% of the HHAs serving white neighborhoods are high quality, as compared to 26% in predominantly black neighborhoods and 28% in Hispanic neighborhoods. 33% of the HHAs in poor neighborhoods are unrated or low quality, as compared to 31% of HHAs in non-poor neighborhoods being unrated or low quality.

Conclusions: Despite a greater number of HHAs serving minority areas, there are racial/ethnic disparities in access to high-quality HH care. Socioeconomic disparities also exist, but at a smaller magnitude. This study provides a signal and potential explanation for why minorities and duals receive care from lower quality HHAs.

Implications for Policy or Practice: Future research to understand HHA practices may help to policies and practices aimed at reducing disparities in access to high-quality HH. For example, policy makers can potentially implement incentive practices that will encourage HHAs to serve historically underserved areas. This is important and timely work because HH is a large and growing form of care, and the greatest geographic variation in overall Medicare spending results from HH.

Primary Funding Source: Agency for Healthcare Research and Quality.

All-Cause and Suicide Mortality Among Lesbian, Gay, and Bisexual Veterans Who Utilize Care through the Veterans Health Administration

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Research Objective: Lesbian, gay, and bisexual (LGB) individuals have higher risk of suicide ideation and attempts than their heterosexual