Crossing the Chasm in Equity: Eliminating Health Care Disparities

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Health is Rooted in Communities

Our Mission for 60 Years:

"To improve the health of our members and the communities we serve"

Noon-hour loudspeaker health education program in Kaiser Shipyard, Richmond. Staff physician talking on the common cold

From *Industrial Medicine*, 14:4, April 1945

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Kaiser Permanente

- Largest non-profit, integrated delivery system
- 35 Hospitals, 431 Medical Centers
- 51.4% of KP's membership are people of color, compared to 35% of the nation
- 56% of KP's workforce are people of color

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Developing the Tools to Measure Disparities

2006

Pair CORE datamart (an outpatient data repository) with zipcode information to impute race/ethnicity and geographic differences in care

2007

Utilize Dr. Amal Trivedi's algorithm with the Medicare population to identify African-American & Caucasian Kaiser Permanente members to evaluate disparities in 4 Diabetes and Cardiovascular disease measures

2009

- Inclusion of RAND algorithm to impute race/ethnicity
- Direct member demographic collection of race/ethnicity and language in outpatient and inpatient settings
- Total Health Assessment from KP.org with self-reported race/ethnicity included in demographics datamart
- Purchase ESRI 2009 Census sample to refine and update RAND algorithm

2010

- Identify patterns of disparity by delivery area
- Evaluate inpatient & outpatient disparities
- Identify and associate patient outcomes with care delivery sites
- Collaborative opportunities between physician group, research and health plan

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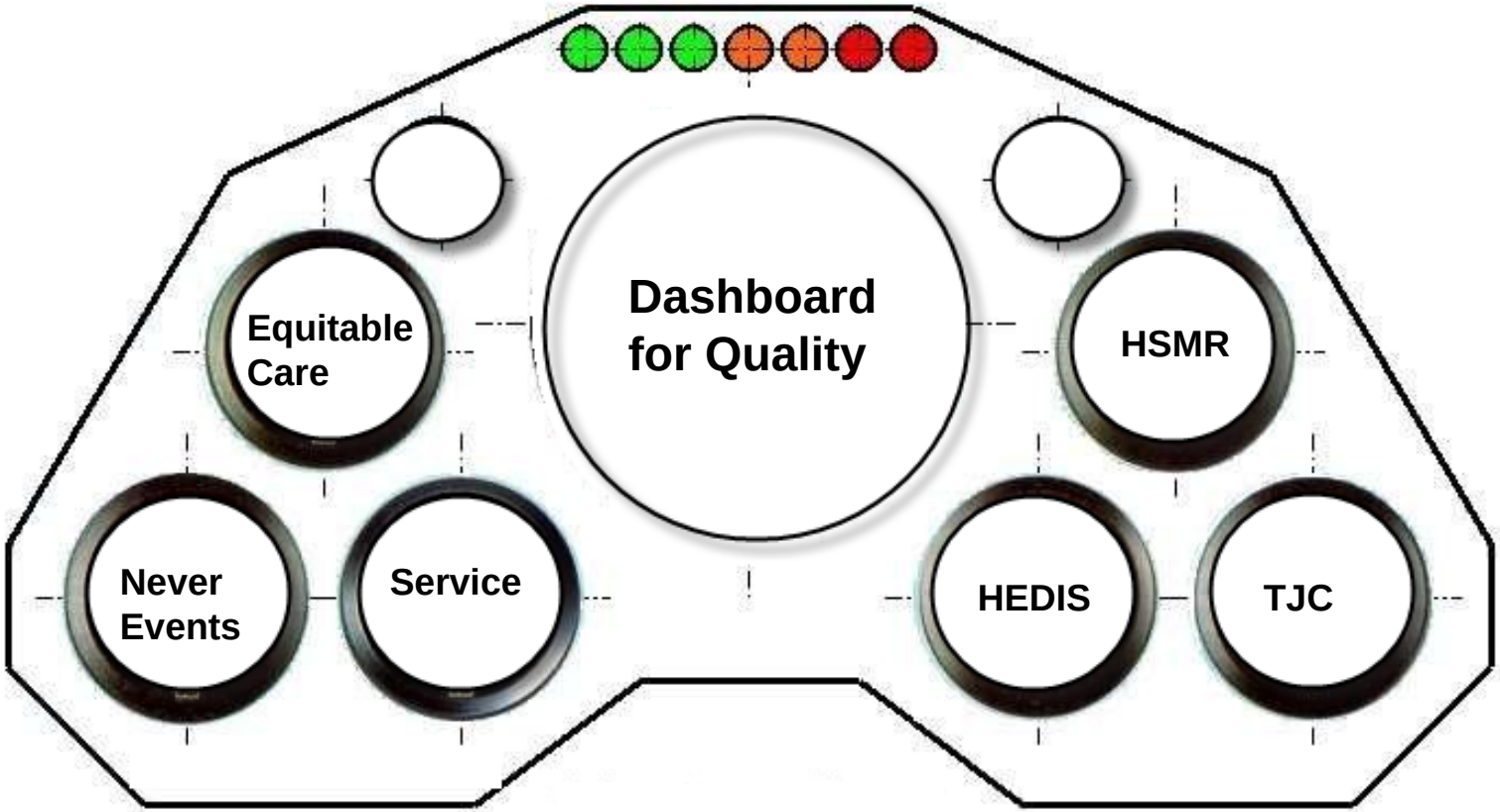
Systematically Measuring Clinical Quality



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The Equitable Care Dashboard: The "HEDIS 16" Measures

Cardiovascular Care

Patients with cardiovascular conditions:
LDL-C screening

Patients with cardiovascular conditions:
LDL-C control (< 100 mg/dL)

Controlling high blood pressure *

Persistence of beta-blocker treatment after a heart attack

Prevention and Screening

Breast cancer screening

Cervical cancer screening

Colorectal cancer screening

Diabetes Care

HbA1c testing

HbA1c control ≤ 9.0%

HbA1c control < 7.0%

Eye exam (retinal) performed

LDL-C screening

LDL-C control (< 100 mg/dL)

Medical attention for nephropathy

Blood pressure control < 130/80 mm Hg

Blood pressure control < 140/90 mm Hg

* Analysis of this measure will begin when 2008 Q4 data become available

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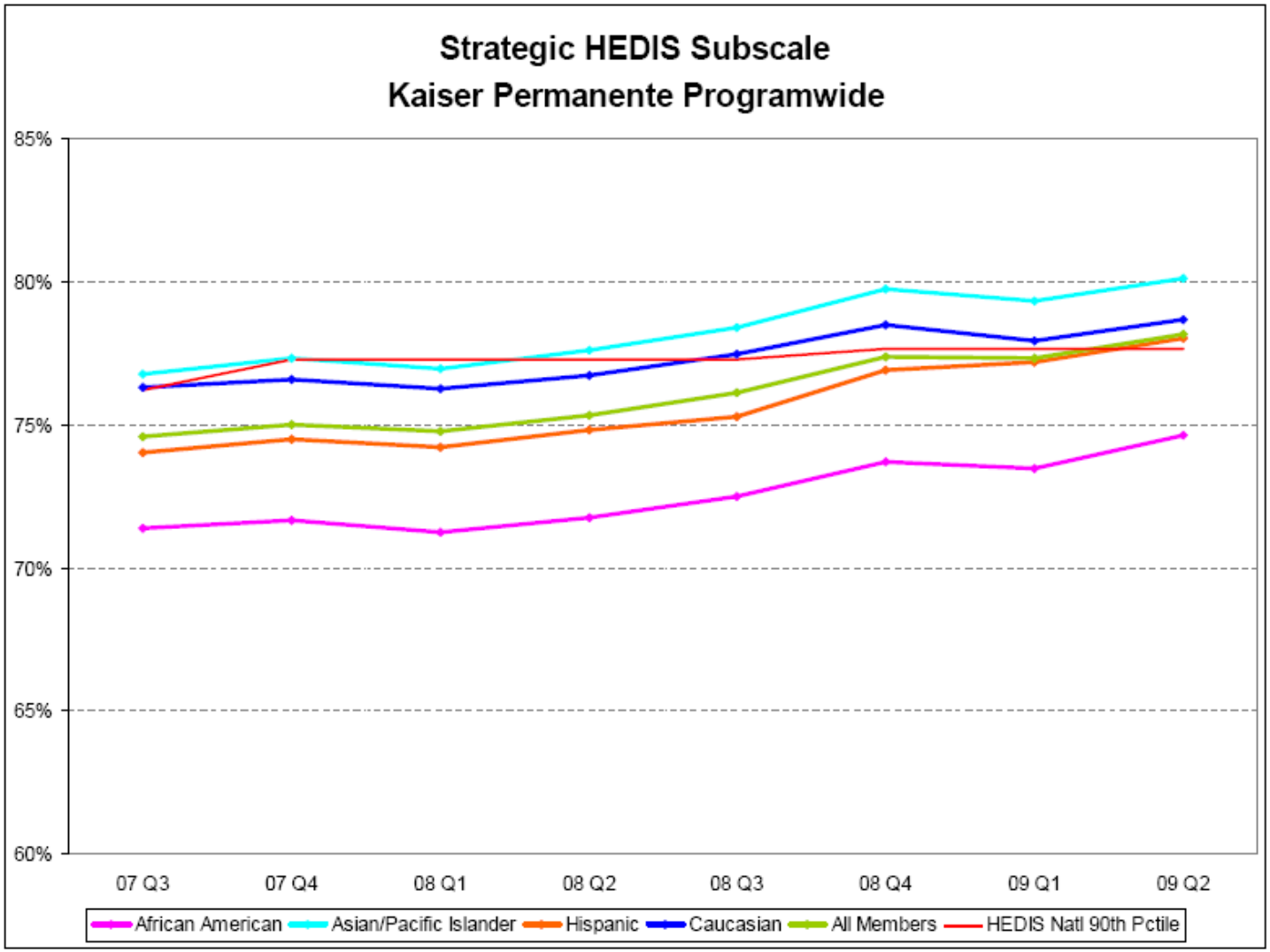
The Equity Composite



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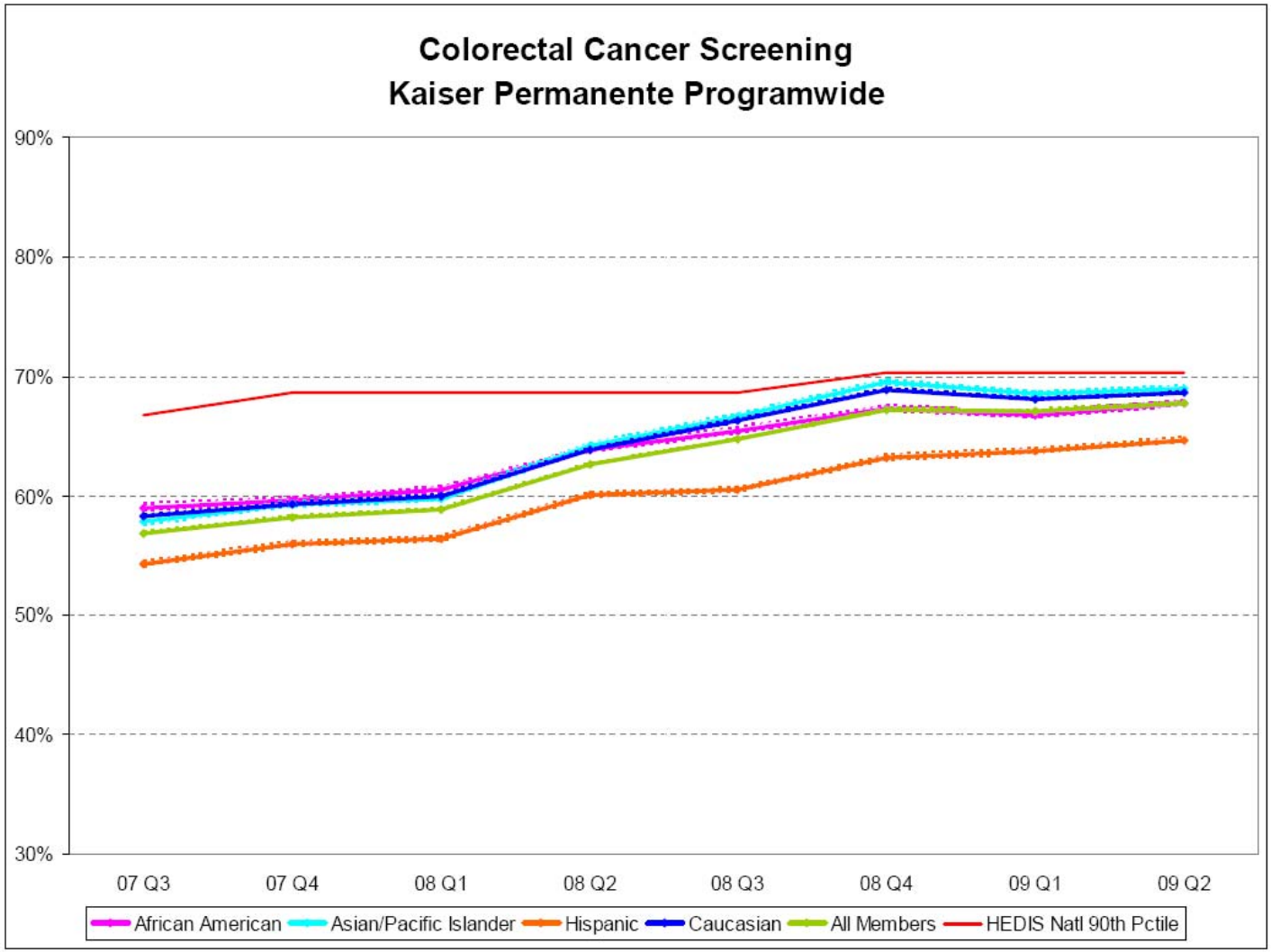
Colorectal Cancer Screening



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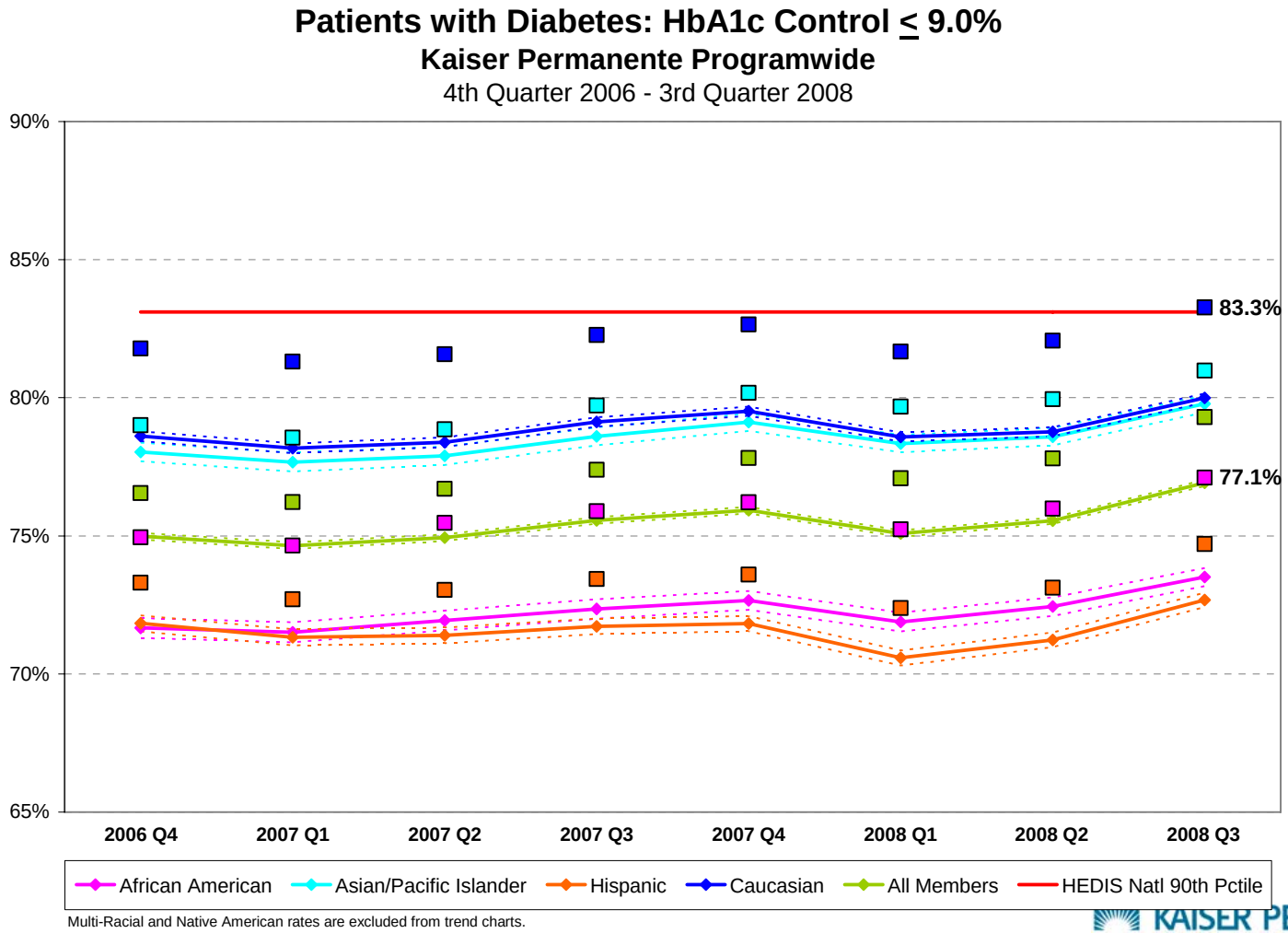
What would we find if we didn't use any race/ethnicity estimates?

Rates are higher, but the pattern is similar – in this example, the African American and Hispanic rates are still more than 6 points lower than Caucasian rate



Multi-Racial and Native American rates are excluded from trend charts.

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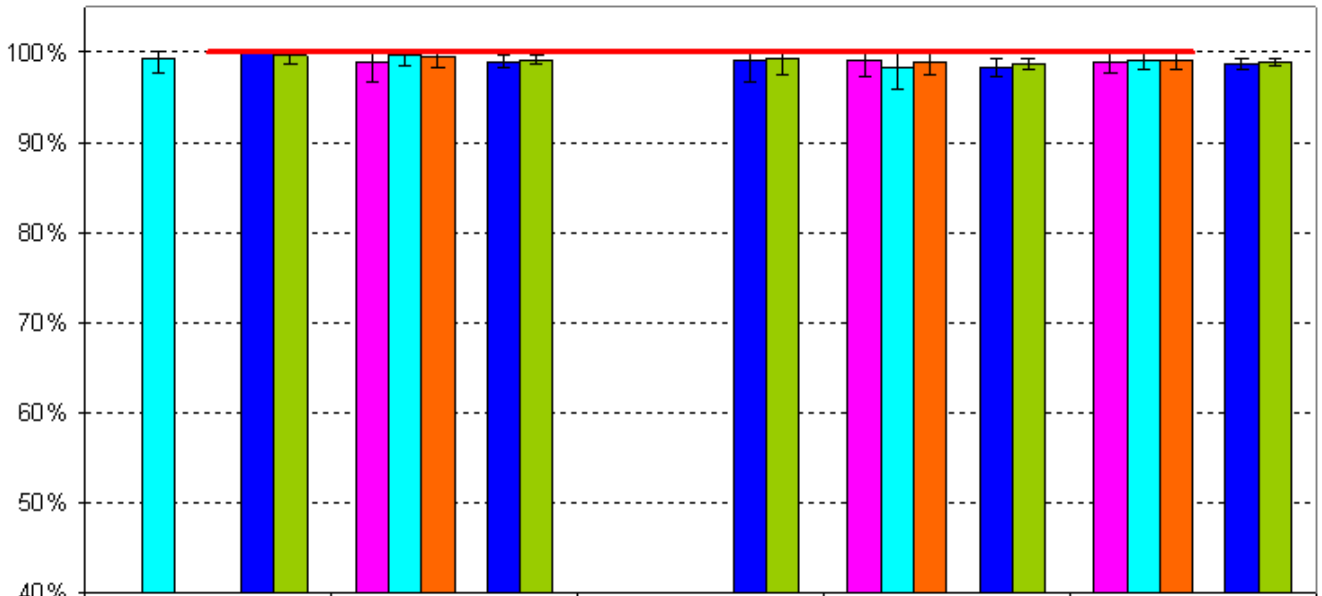
Measuring Disparities in Inpatient Care

AMI-5: Beta-blocker Prescribed at Discharge

Study Period: Jan - Dec 2008



					Kaiser Permanente
African American		98.8%		99.1%	99.0%
Asian/Pacific Islander	99.3%	99.6%		98.3%	99.1%
Hispanic		99.5%		98.8%	99.1%
Native American					
Caucasian	100.0%	98.9%	99.0%	98.4%	98.7%
All Members	99.6%	99.1%	99.3%	98.6%	98.9%
TJC Natl 90th Pctile	100.0%	100.0%	100.0%	100.0%	100.0%

Identifying Intervention Levels

Level 1

- Single measurable event
- Patient commitment either “opt out” or “opt in”
- Examples: Screening measures; pnuemococcal vaccines for adults

Level 2

- Outcomes achieved over sustained clinical exposures with multiple patient touches
- Patient engagement – intermediate to high
- Examples: Hgb A1c levels; hypertension control; lipid control

Level 3

- Highly dependent on impacting social determinants of health with early interventions & multiple community stakeholders
- Long periods of engagement with community and patients
- Examples: low birth weight infants (infant mortality); HIV prevalence; Obesity reduction

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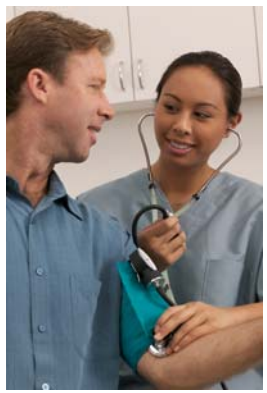
What's Next? Identifying Effective Interventions in Disparities Reduction

Example: One Kaiser Permanente's region has an *inverse disparity* among African American and Caucasian patients.

Identify: The strategies employed to improve hypertension control among African American patients

Components:

Utilizing HealthConnect[tm] to review provider panels and flag hypertensive patients



Team based approach – nurses intensify care management for patients via phone calls and face-to-face appointments

Drop in care management available

No fee associated with chronic care intensification

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Thank You!

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