Addressing Disparities in Health Outcomes through HIT

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HEALTH SERVICES

- 15 Community Health Centers
- 8 Homeless healthcare sites
- 2 School based health programs
- 3 Dental centers
- 2 Mental health centers
- 2 Free clinics
- 275,000 visits / 70,000 patients

HEALTH PROFESSIONAL EDUCATION

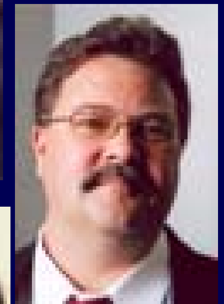
- 2 Family Practice Residency Training programs- one rural underserved , one urban underserved

SPECIAL PROGRAMS

- 40 Grant Programs including
- Registered PBRN, In-house IRB

STAFF AND BUDGET

- Over 630 staff members:
- Budget of 54 million dollars annually



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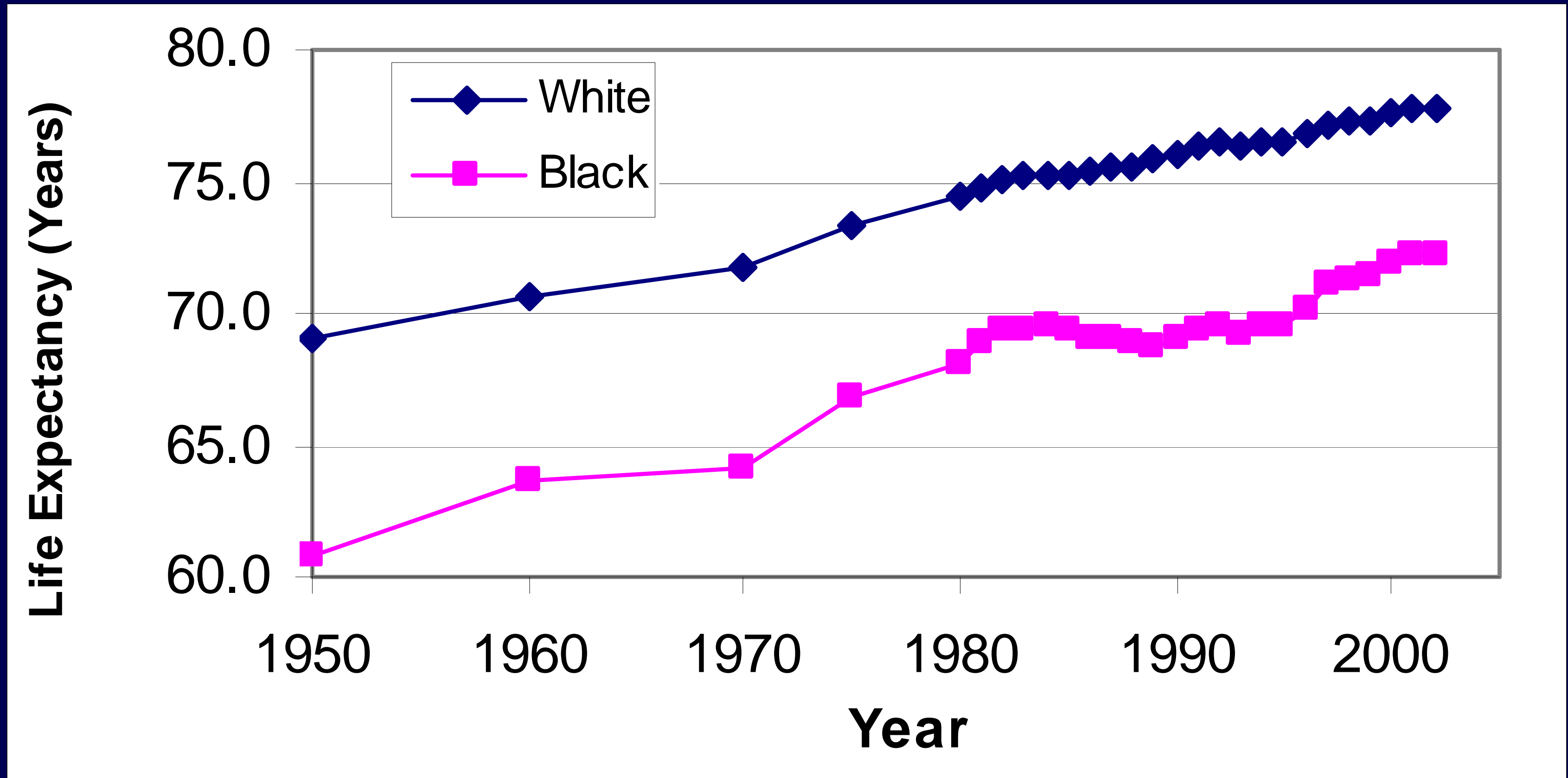
Life Expectancy at Birth



SOURCE: CDC/NCHS, Health, United States, 2004

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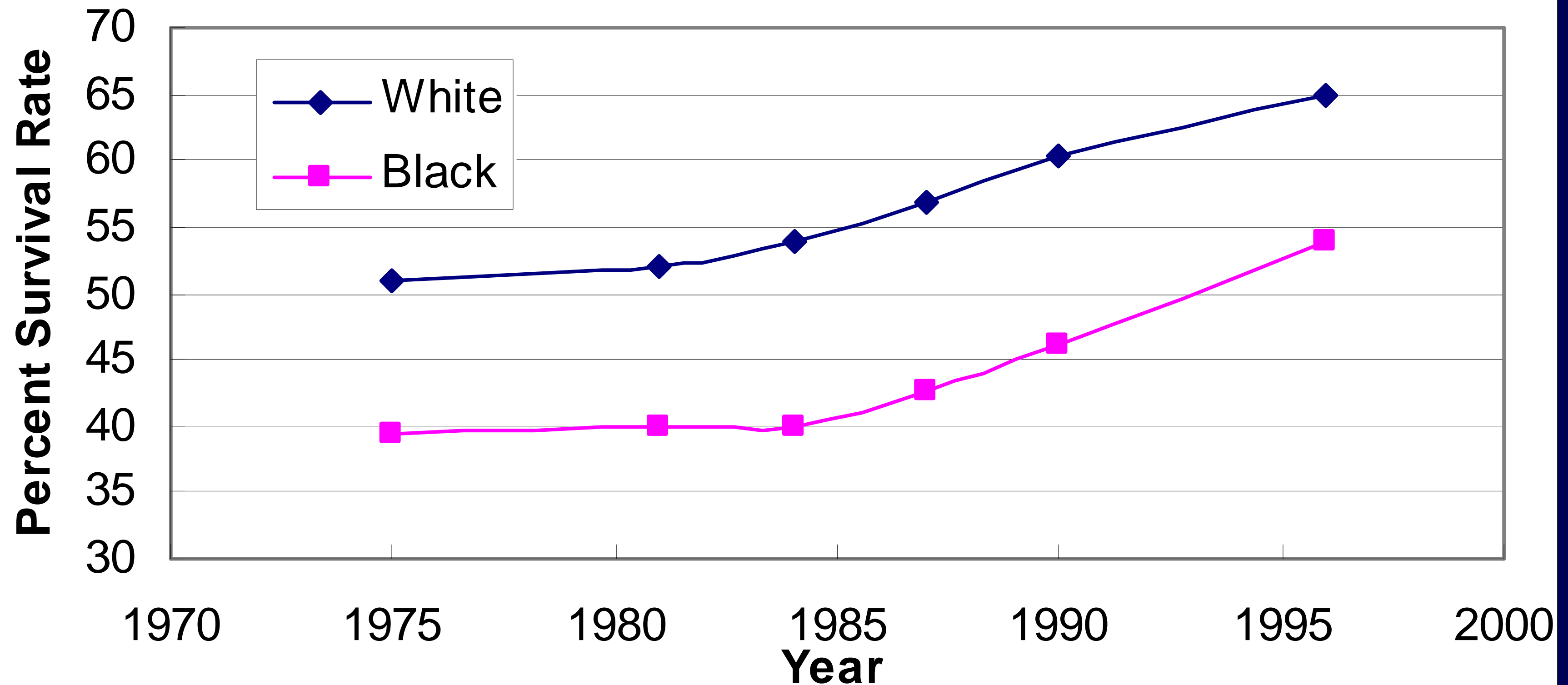
Five-year Cancer (all sites) Survival Rate



SOURCE: CDC/NCHS, Health, United States, 2004

Infant Mortality Rates

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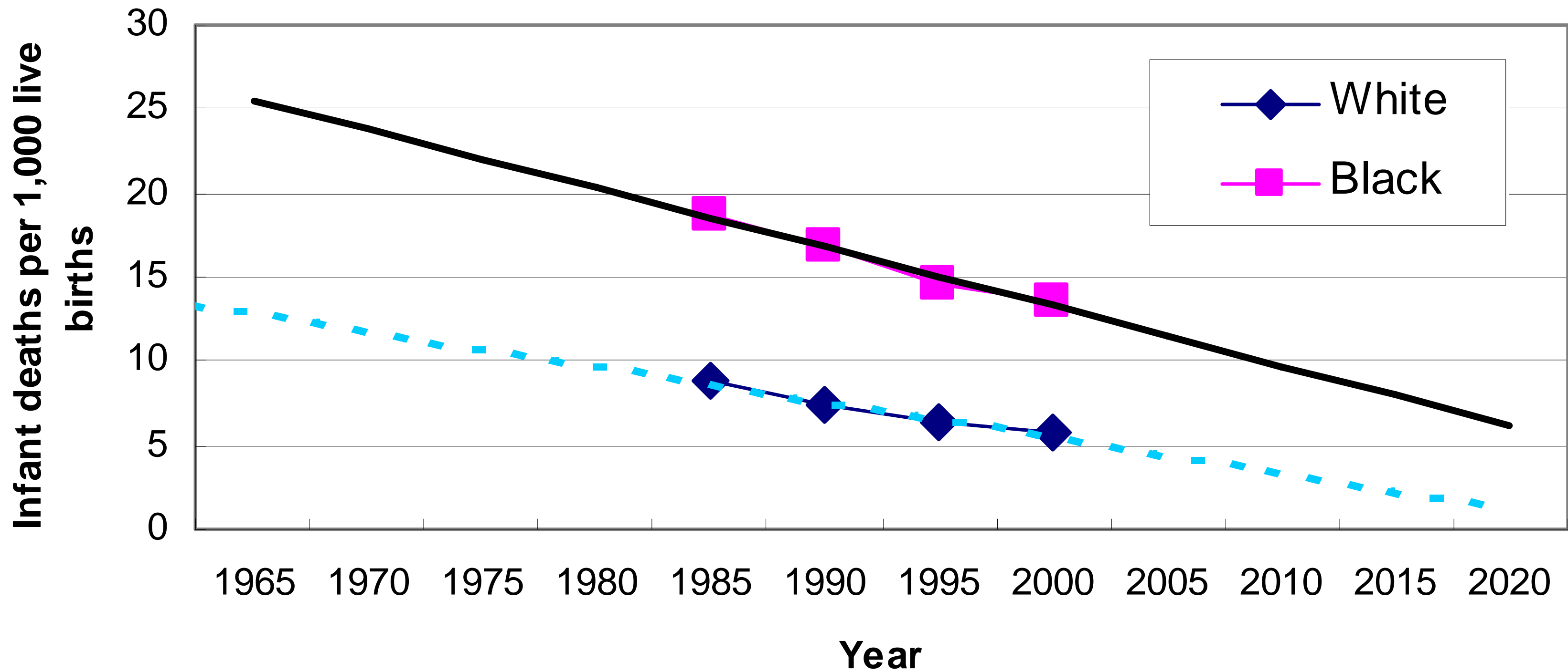
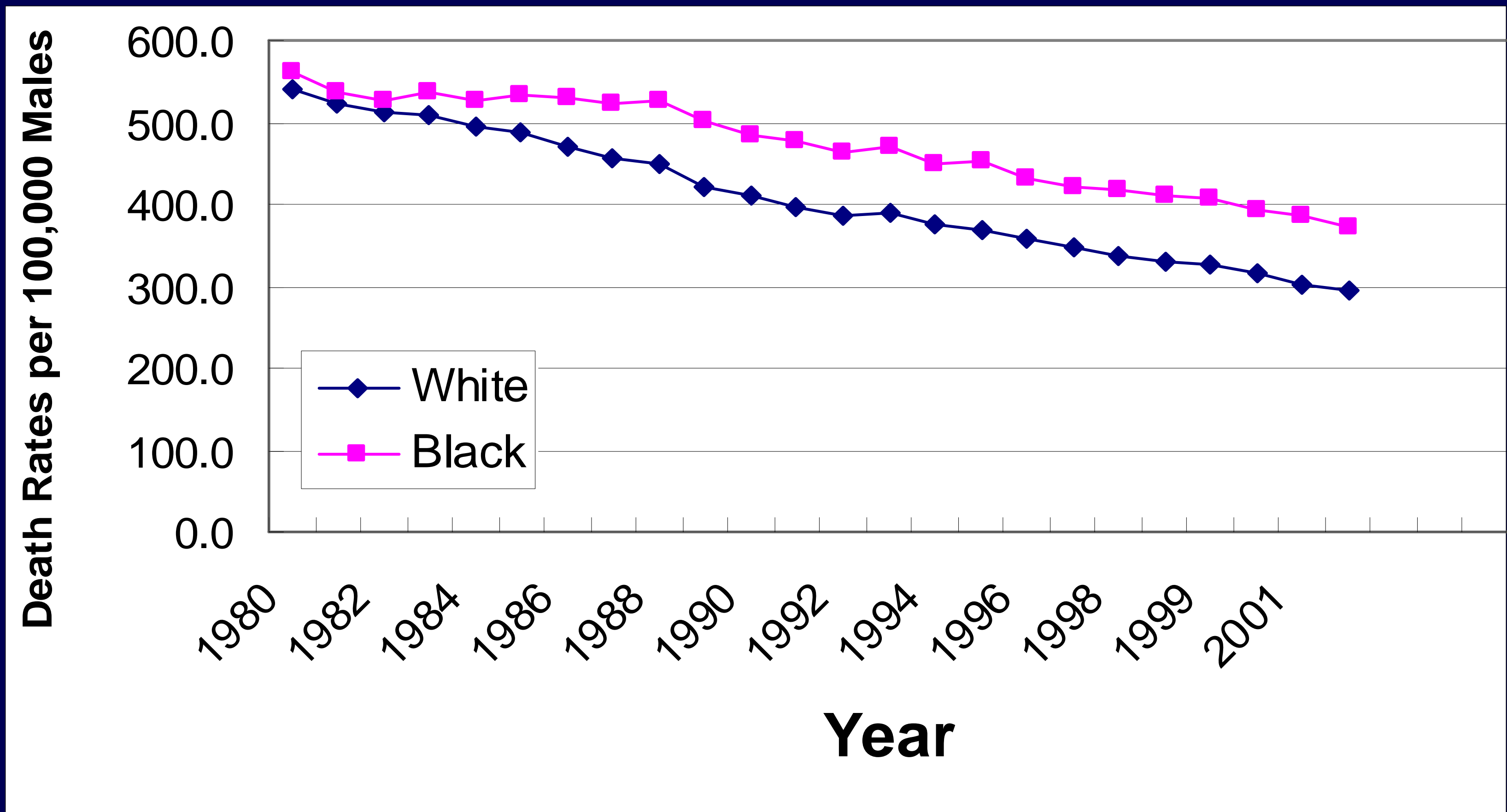


SOURCE: CDC/NCHS, Health, United States, 2004

Age-adjusted death rates for diseases of the heart per 100,000 males



SOURCE: CDC/NCHS, Health, United States, 2004

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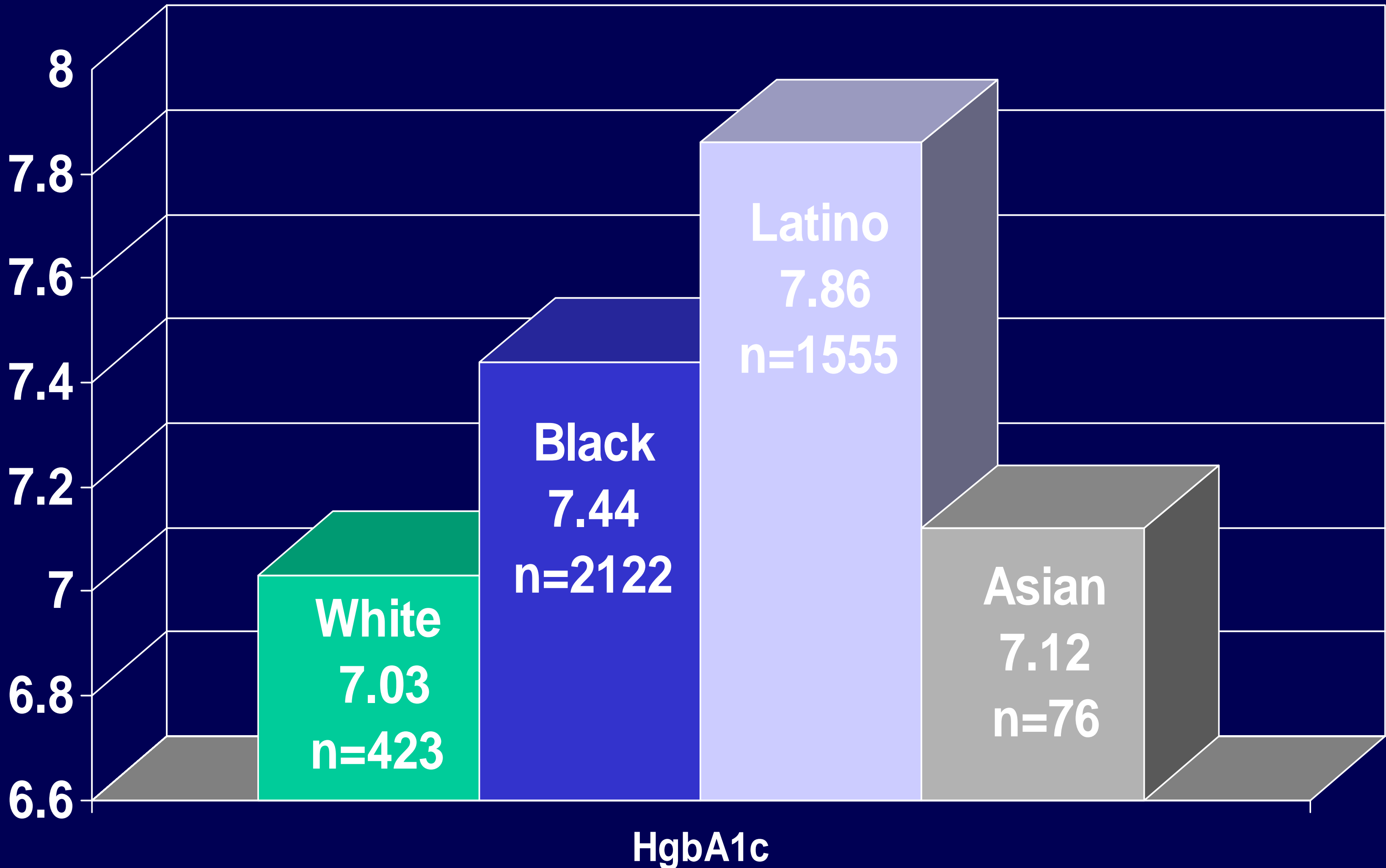
Last Hemoglobin A1c by Race

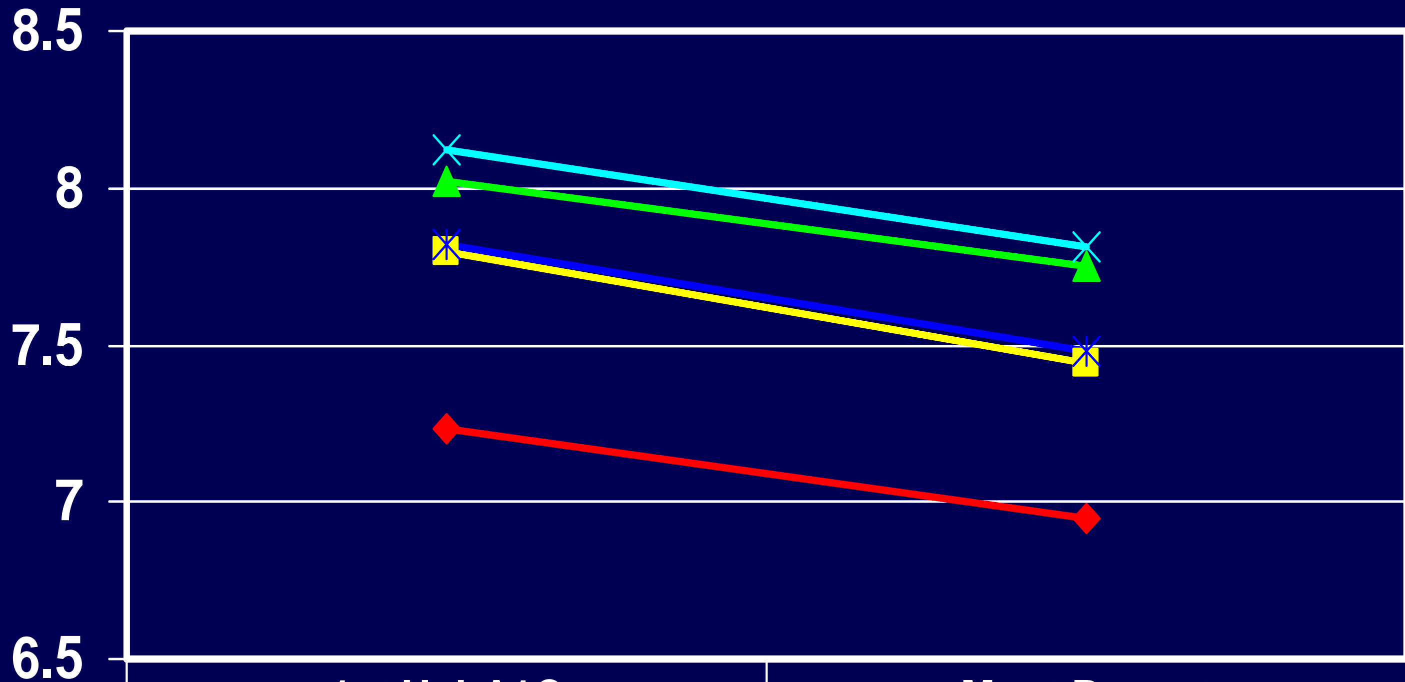


What happens in the year following patients' first high hba1c test ?

Measure	White	Black	Hisp	P
Average number of office visits	5.6	6.6	6.3	.009
Received a nutrition referral (%)	15	20	17	.169
Received 1 or more hba1c tests (%)	81	83	82	.813
Received 2 or more hba1c tests (%)	51	53	50	.496
Received prescription for insulin	25	27	26	.828
Received presc. for other diabetes med	75	81	86	.001
N	150	1021	777	

N represents all patients whose last recorded office visit was at least 365 days after the patient's first recorded hba1c test with a value of 7.5 or greater.

Reductions in HgbA1c with Treatment by Race /Language



	1st HgbA1C	Most Recent
White	7.23	6.95
Black	7.80	7.44
Latino-Eng	8.02	7.75
Latino- Span	8.12	7.81
Other	7.82	7.48

Average Last HgbA1c each provider's diabetic patients vs. their rate of nutrition referral

Most Recent HgbA1C

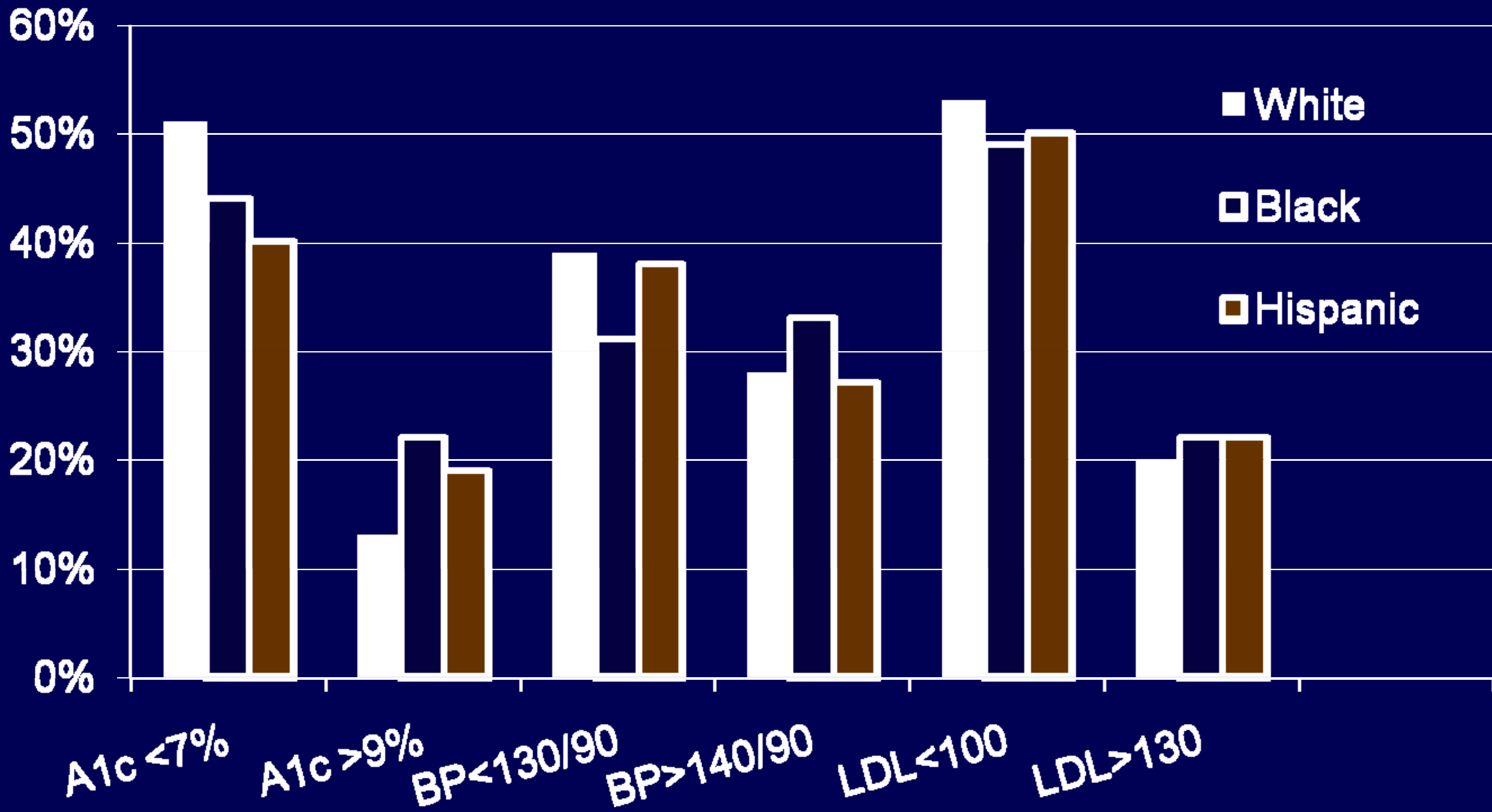
9
8.5
8
7.5
7
6.5

21
1
12
9

0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%
70.0%

Rate of Nutrition Referral

Racial Disparities in A1c, BP and LDL Control at the Institute



As of 3-15-2010

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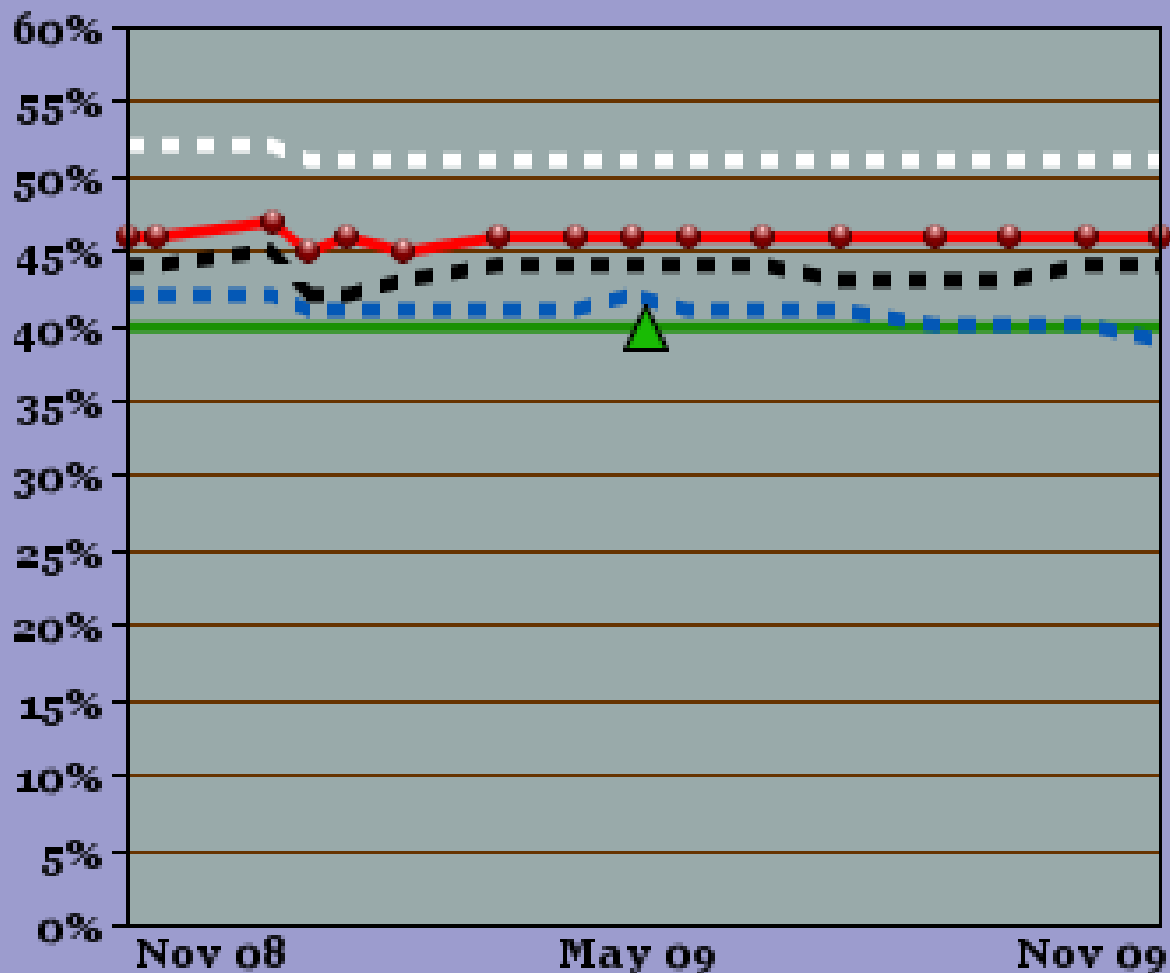

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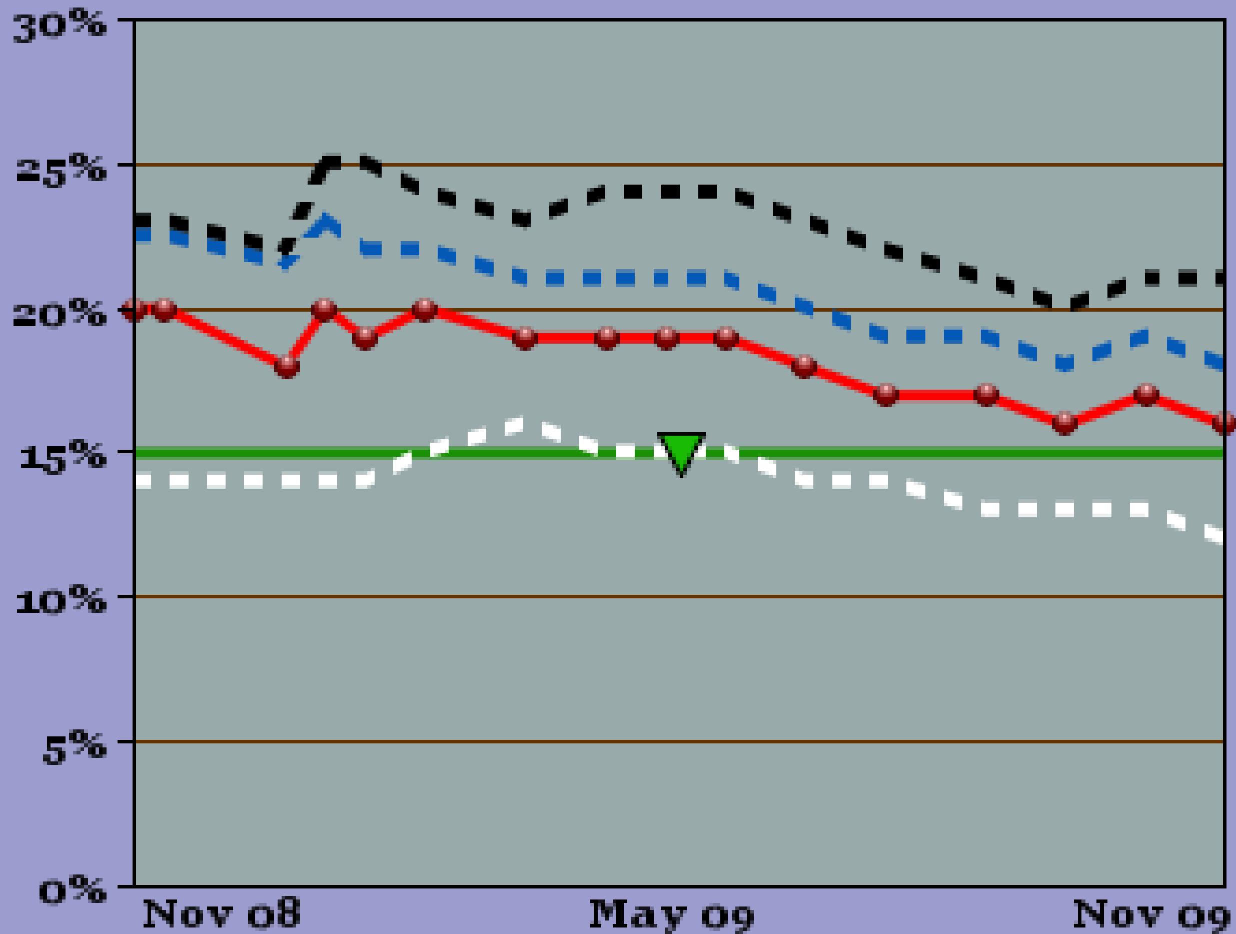

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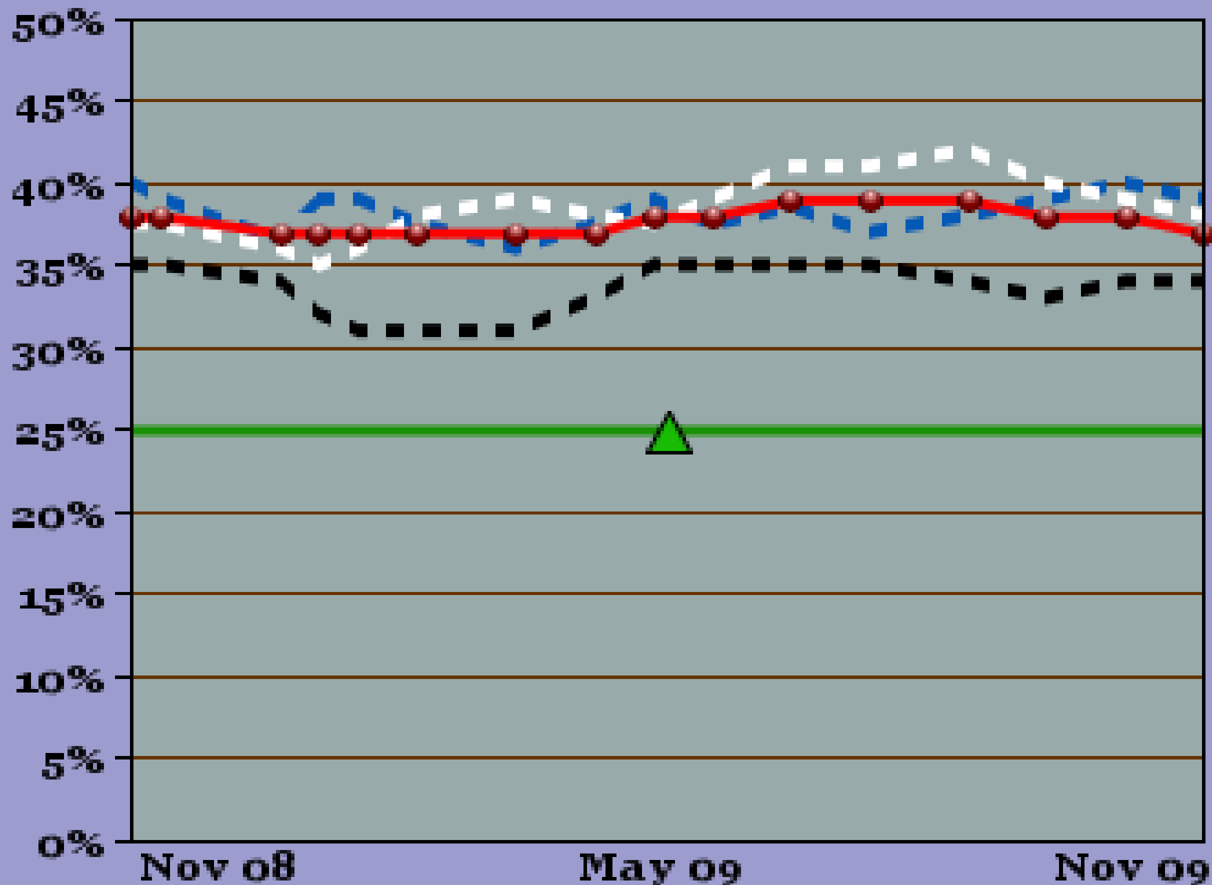
BP < 130/80 (Goal is >25% of panel)



INSTITUTE AVERAGE

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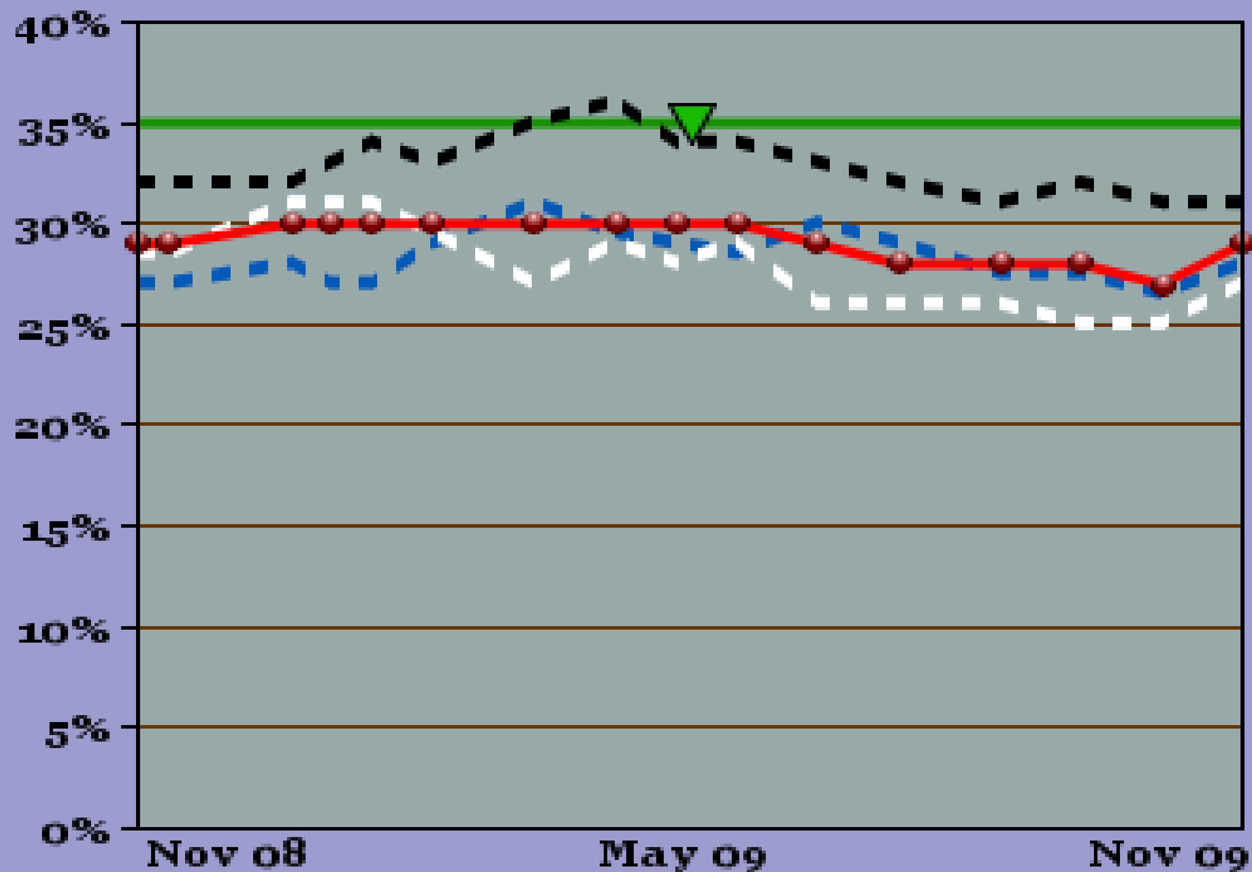

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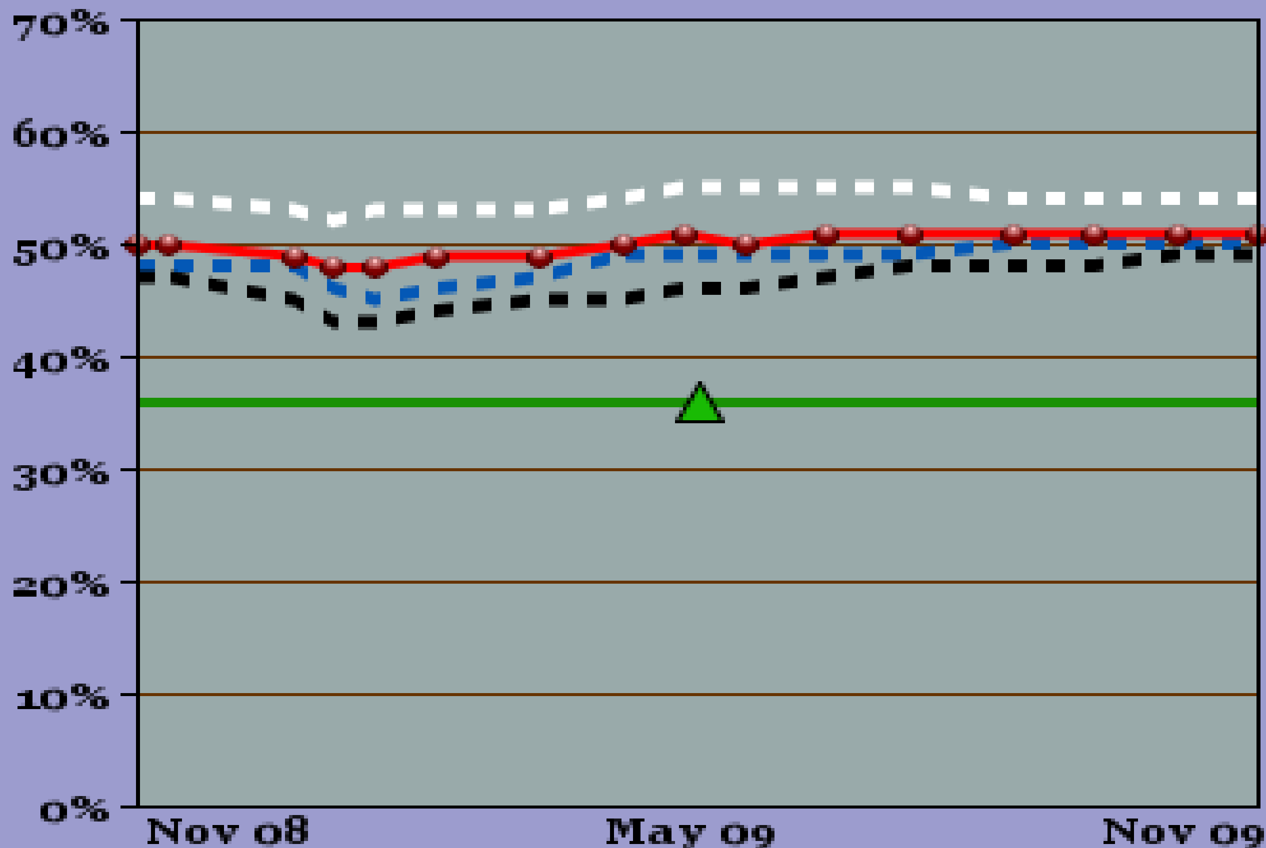

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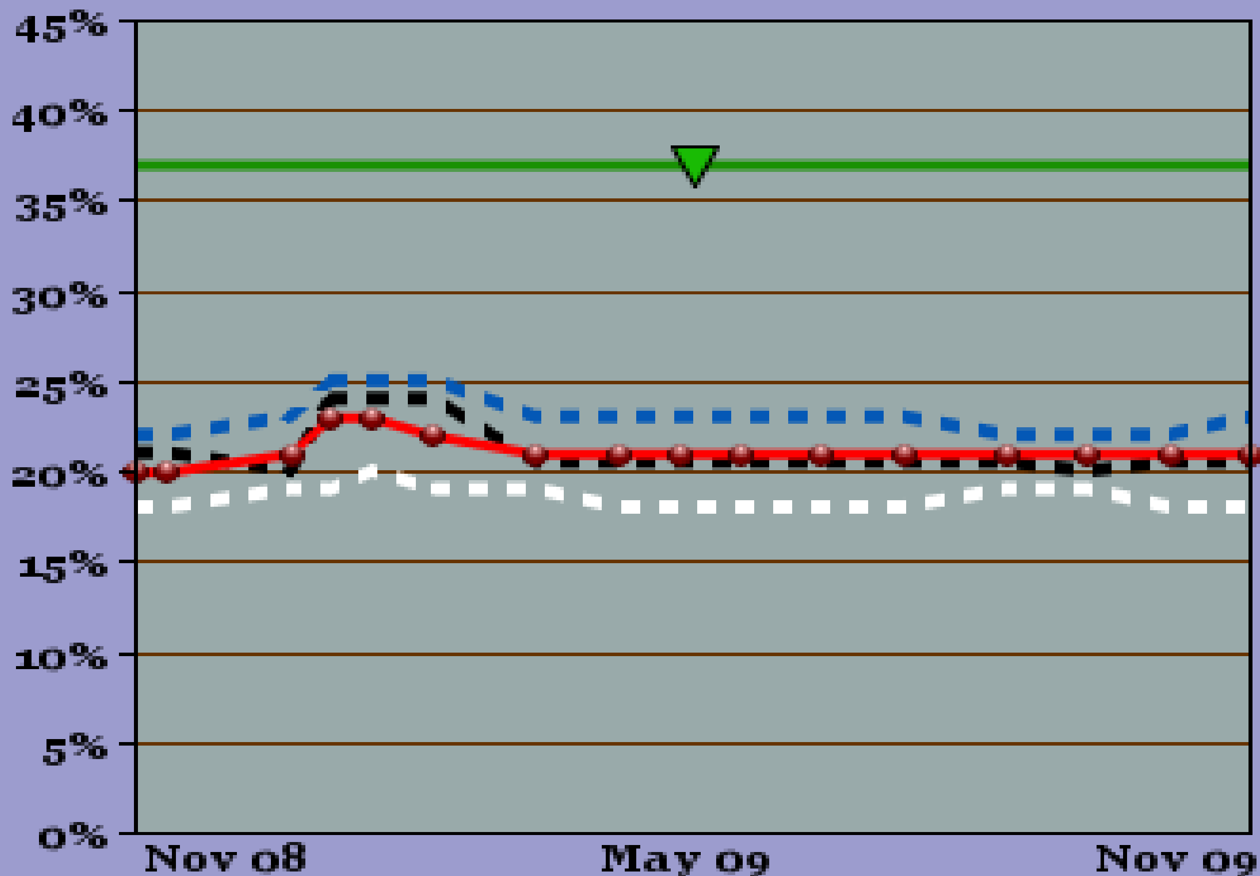
LDL >= 130 (Goal is <=37% of panel)

INSTITUTE Black White Hispanic



INSTITUTE AVERAGE

Interventions that are being targeted to those patients whose A1c is >8.0

Type	Intervention
EHR	Diabetes Registry
	Diabetes Disparity Reports
	Clinical Alerts for Uncontrolled A1C, BP, Lipids
Personnel	Hired Diabetes Educators
	Established Diabetes Medical Director
	Staff Education
Workflow	More frequent visits for DM patients wit A1c >9
	Outreach to those who do not have follow-up appointments
	Onsite A1C testing
	CDE led diabetes group visits
	Assigned monofilament testing to nurses
	Screened all diabetics for depression with PHQ-2

The challenge is how we use what we learn about health disparities

to support the changes that we can make in our practices to reduce or eliminate disparities in health outcomes