Kaiser Permanente’s Approach to Health Disparities

• Michael H Kanter MD
• Professor and Chair, Clinical Sciences, Kaiser Permanente School of Medicine
REAL THE STRUGGLE IS...
Crossing the Quality Chasm - Six Aims

IOM Quality of Healthcare in America

- Safe
- Effective
- Patient Centered
- Timely
- Efficient
- Equitable
United States demographics

By 2050 it is projected that

- More than half of the population will be non-white
- Latino population will triple
- Asian population will triple
- Black population will double
- White population will stay about the same
Health disparities

This can involve

- Race/ethnicity
- Gender
- Age
- Socioeconomic status
- Sexual orientation
- Disability status
- Language preference
- Anything that differs among people that should not impact care
Health disparities

• Are unacceptable
• Occur in the context of racial and ethnic or other discrimination
• Have many sources
  • Health systems
  • Bias – both conscious and unconscious
  • Cultural
  • Societal
Factors contributing to health disparities

Intrinsic Factors

Extrinsic Factors

Total Health

Intrinsic Factors
Potential Myocardial Infarctions/Strokes Prevented

11.2 MILLION African Americans in U.S. with hypertension

6.3%\text{\%} DIFFERENCE in control rate between U.S. African American and U.S. Caucasian (70.2\text{\%} vs. 63.9\text{\%})
Hypothetically... If hypertension control disparity reduced to 0

7,056,000
MI or Stroke =
1 MIs or Strokes Potentially Prevented
in 5 years (11 per day)

TREAT 36 PATIENTS
Disparities in control of blood pressure, cholesterol, and glucose...for blacks in Medicare...were eliminated [by Kaiser Permanente] in 2011.

New England Journal of Medicine; 371:24, NEJM.ORG
“Racial and Ethnic Disparities among Enrolees in Medicare Advantage Plans
John Z. Ayanian MD, etal December 11,2014
Disparities

“The IHS[Kaiser Permanente] approach to care is associated with higher levels of evidence-based medicine, improved survival, and reduced colon cancer disparity gaps.”

Journal of Clinical Oncology Published Ahead of Print on January 26, 2015 as 10.1200/JCO.2014.56.8642
“How Do Integrated Health Care Systems Address Racial and Ethnic Disparities in Colon Cancer?”
Kim F. Rhoades, et al
Two Approaches to Address Disparities

Address each metric individually
• Suppose...
  • 500 quality measures
  • 300 race/ethnicity groups captured in system
  • How many permutations?

Address more than one issue
• Create a highly reliable delivery system
• Language
• E disparities
• Proper location of MOBs
• Deal with social determinants of health
• Training physicians in disparities reduction
Are health care disparities in part a manifestation of unreliable non-standardized care

• Example: colon cancer screening
  • What if the health care system was set up such that 100% of the patient population that needed colon cancer screening obtained it
    • Proactive care
    • Robust outreach
    • On-line tools for self-management
    • Involvement of every place that contacts patients
Standardization

- Contrary to the idea of physician autonomy
- May be incorrectly interpreted as inhibiting creativity and innovation
- Difficult to show that one way of doing things is better than another
- Standardized processes are not necessarily reliable
reliability

• Standardized systems may not be reliable
• Reliable systems are standardized
• Systems that rely on human beings too much are not reliable
• Systems that rely on computers are highly reliable until they are not.
Standardization

• The more different workflows are, the harder it is to identify and spread best practices

• Allows for easy spread if medical centers all have standardized workflows
  • POE
  • BPAs
  • Safety Net program
In the Old Days...

- Doctors practiced medicine
- No scientific methods for practice improvement
Lack of systems

• Most physicians open or join a “practice”
• There are few systems in place in the “practice”
• Lack of systems allows unreliable care, which then increases health care disparities
Aim of Improvement

Measurement of Improvement

Developing a Change

Testing a Change

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Quality Measure Improvement Over Time

Adult Hypertension Control Ages 18-84, 2004-2014
Source: SCPMG Department of Clinical Analysis
Organizational Change and Learning

Complete Care at Kaiser Permanente: Transforming Chronic and Preventive Care

Michael H. Kanter, MD; Gail Lindsay, RN, MA; Jim Bellows, PhD; Alide Chase, MS

The Chronic Care Model (CCM) aims to transform care for patients with chronic illnesses through six interrelated system changes: health system, delivery system design, decision support, clinical information systems, self-management support, and community resources. It has stimulated innovative models

Article-at-a-Glance

Background: In 2004 Kaiser Permanente Southern California (KPSC) recognized the potential to improve the quality of care. Healthcare Effectiveness Data and Information
HEDIS Results

<table>
<thead>
<tr>
<th>Results</th>
<th>Commercial</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total measures</td>
<td>25</td>
<td>26</td>
</tr>
<tr>
<td>Above US 90&lt;sup&gt;th&lt;/sup&gt; percentile at baseline</td>
<td>10 (40%)</td>
<td>11 (42%)</td>
</tr>
<tr>
<td>Above US 90&lt;sup&gt;th&lt;/sup&gt; percentile by 2012</td>
<td>19 (76%)</td>
<td>22 (85%)</td>
</tr>
<tr>
<td>Average KPSC improvement, baseline to 2012</td>
<td>13.3%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Average improvement in US median, baseline to 2012</td>
<td>5.6%</td>
<td>5.4%</td>
</tr>
</tbody>
</table>

KPSC improvement was 2-3 times greater than median US health plans
“The Whiskey Barrel”
Proactive Panel Support

• Panel Manager
  • PharmD, RN, RNP, PA

• Support Coordinator
  • Clerk, LVN, MA

• Scheduled Physician Time
  • 20 to 60 minutes per month
# Proactive Office Encounter (POE)

<table>
<thead>
<tr>
<th>Pre Visit</th>
<th>Visit</th>
<th>Post Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Proactive Identification</strong></td>
<td><strong>Office Encounter</strong></td>
<td><strong>Immediate:</strong></td>
</tr>
<tr>
<td>- Identify missing labs (A1c, LDL, microalbumin), screening procedures,</td>
<td>- Pre-encounter follow-up</td>
<td>- After visit summary, after care instructions, follow-up appointments,</td>
</tr>
<tr>
<td>access management, KP.org status, etc.</td>
<td>- Vital sign, history, social, demographics, medication review</td>
<td>health materials, how to access info on KP.org</td>
</tr>
<tr>
<td>- Provide member instructions prior to visit</td>
<td>- Identify and flag alerts for provider for screening and uncontrolled chronic conditions</td>
<td></td>
</tr>
<tr>
<td>- Contact member and document encounter in HealthConnect™</td>
<td>- Room and prepare patient for necessary exams</td>
<td>- Follow up contact &amp; appointments per provider</td>
</tr>
</tbody>
</table>

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**Immediate:**
- After visit summary, after care instructions, follow-up appointments, health materials, how to access info on KP.org

**Future:**
- Follow up contact & appointments per provider
Two Approaches to Address Disparities

Address each metric individually
• Suppose...
  • 500 quality measures
  • 300 race/ethnicity groups captured in system
  • How many permutations?

Address more than one issue
• Create a highly reliable delivery system
• Language
• E disparities
• Proper location of MOBs
• Deal with social determinants of health
• Training physicians in disparities reduction
Language disparities

LEP patients are more prone to

• Medical error
• Extra diagnostic testing
• Overly aggressive hospital admissions
• Health disparities
• Miscommunication issues
Language concordance

- Physicians pass a standard language test
- Physicians have option to increase the % of LEP patients in practice
- Annual incentives to qualifying concordant physicians
- 23 language fluency programs offered

Exists when a bilingual physician is fluent in the language that his/her patient prefers to speak
Better Blood Pressure Control With Spanish Speaking Physicians

The HTN control rate when paired with concordant MD tends to show a significant improvement of up to 2%.
## Impact of language concordance on quality

<table>
<thead>
<tr>
<th>2012 Quality Measures</th>
<th>Non-Spanish Speaking</th>
<th>Spanish Speaking</th>
<th>Spanish Speaking with Concordant MDs</th>
<th>Spanish Speaking with Non-Concordant MDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipid Control (&lt;100 mg/dL) with Diabetes</td>
<td>68.3</td>
<td>67.7</td>
<td>68.1</td>
<td>66.4</td>
</tr>
<tr>
<td>HbA1c &lt; 9.0% with Diabetes</td>
<td>83.3</td>
<td>81.3</td>
<td>81.9</td>
<td>79.5</td>
</tr>
<tr>
<td>Colon Cancer Screening</td>
<td>79.3</td>
<td>78.3</td>
<td>79.6</td>
<td>74.9</td>
</tr>
</tbody>
</table>

All p values are < .05
## Language Concordance - Impact on Quality

<table>
<thead>
<tr>
<th>2015* Quality Measures</th>
<th>General Population Screening Rate</th>
<th>Spanish Speaking Member with Non-Concordant MDs</th>
<th>Spanish Speaking Member with Concordant MDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes HbA1c &lt; 8%</td>
<td>66.8%</td>
<td>62.7%</td>
<td>64.8%</td>
</tr>
<tr>
<td>Controlling Blood Pressure</td>
<td>88.8%</td>
<td>88.9%</td>
<td>89.8%</td>
</tr>
<tr>
<td>Colon Cancer Screening</td>
<td>82.7%</td>
<td>79.1%</td>
<td>83.6%</td>
</tr>
</tbody>
</table>

Source: Culturally Responsive Care Dept.
2Q 2015 KP SCAL Equitable Care Report Language
Primary care program trends

Concordant Visits

- Inception: 24.6%
- 2008: 32.0%
- 2009: 33.9%
- 2010: 35.6%
- 2011: 36.0%
- 2012: 37.8%
- 2013: 37.7%
- 2014 YTD: 43.6%
E disparities

• Use of patient portals is rapidly increasing.
• What if its use is not the same for all racial/ethnic groups?
• What if use of such portals improves patient outcomes?
• Are we increasing health disparities?

Health Affairs 2010;29(7):1370-1375.
Findings – Disparity among race/ethnic groups in access to patient portal (kp.org)

Other factors include age, gender, disease burden, income level, education, language preference, number of doctor office visits, region, tenure with KP and distance to nearest MOB.
Quality of care improvement and secure Email

Matched Control Study: Secure Email Users vs Non-Users

- A1C Screening
- A1C Controlled (<9)
- LDL Screening
- LDL Controlled (<100)
- Retinopathy Screening
- Nephropathy Screening
- BP Control (<140/90 mmHg)

Non Secure Email Users
Secure Email Users
Disparities exist in Portal usage

HEDIS scores increase in patients who started using the Portal from 1.0-7.1% more than patients who did not use the Portal

HEDIS increases were similar in Non-Hispanic White, Latino, African American, and Asian populations

Increasing portal usage in minorities has the potential to decrease health disparities
Social determinants of health

• Potentially a huge lever on health disparities
• Addressing social determinants of health has an unclear path forward with boundary issues of what is the role of health care organizations and what is the role of society/communities
• Good studies on how to do this at scale are lacking
How Many Members Have Unmet Social Needs?

<table>
<thead>
<tr>
<th>Step</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Answer call</td>
<td>52%</td>
</tr>
<tr>
<td>Agree to take screen</td>
<td>36%</td>
</tr>
<tr>
<td>Have 1+ needs</td>
<td>28%</td>
</tr>
<tr>
<td>Enroll</td>
<td>21%</td>
</tr>
</tbody>
</table>

Source: Kaiser Permanente/Health Leads Partnership
What is the social need prevalence of top 1% at screening?

<table>
<thead>
<tr>
<th>Question</th>
<th>% Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Within the last 12 months, “the food that I bought just didn’t last, and I didn’t have money to get more.”</td>
<td>44%</td>
</tr>
<tr>
<td>2. Within the last 12 months, “I couldn’t afford to eat balanced or healthy meals.”</td>
<td>46%</td>
</tr>
<tr>
<td>6. Do you have difficulty arranging for transportation to or from your medical appointments?</td>
<td>35%</td>
</tr>
<tr>
<td>7. Do you ever have trouble making ends meet at the end of the month or worry about money matters?</td>
<td>60%</td>
</tr>
<tr>
<td>7a. Do you need help finding ways to pay for your utility bills?</td>
<td>33%</td>
</tr>
<tr>
<td>7d. Do you need help finding ways to pay for medical care?</td>
<td>33%</td>
</tr>
<tr>
<td>8. How often do you have problems learning about your medical condition because of difficulty understanding written words or numbers?</td>
<td>36%</td>
</tr>
<tr>
<td>11. How often do you feel lonely or isolated from those around you?</td>
<td>30%</td>
</tr>
</tbody>
</table>

Source: Kaiser Permanente/Health Leads Partnership
Unmet Social Needs

Meet Patient Carlos
• Multiple Sclerosis
• Uncontrolled diabetes

• Multiple ED visits, hospitalizations
• Missed specialty visits

• Spanish speaking
• Financial difficulties
After Social Needs Recognized

Patient Carlos

- Improved health
- Trusts health team
- Keeps appointments
- Medication adherence
Example of focus on a specific conditions- high blood pressure

Focus on African Americans

• Overall blood pressure control in the U.S. is suboptimal
  • Over ½ of Americans with hypertension not well controlled

• Severe in African American population
  • About 42% among adults

• As compared to Caucasians:
  • 1.3 times greater risk of non-fatal stroke
  • 3 to 6 times greater risk of fatal stroke
  • 5 times greater risk for End Stage Renal Disease
Barriers to accomplishing these components among African Americans

• Failure to intensify therapy

• Patient-clinician relationship
  • Duration/frequency of relationship
  • Patient satisfaction

• Health care access
  • Non-attendance at scheduled visits
  • Non-adherence to medicines/labs

• Patient
  • Knowledge
  • Diet/exercise
  • Support/resources
approaches to hypertension disparities reduction

• Salt questionnaire
• Tailored communication training to build trust
• Community outreach activities
• Storytelling by videos
• African American group hypertension visits
• Use of barber shops in African American neighborhoods
• Targeted panel management
## Improving patient-provider communications and interactions

### Four Habits

- Invest in the beginning
- Elicit patient’s perspective
- Demonstrate empathy
- Invest in the end

### AIDET®

- Acknowledge and Introduce
- Duration
- Explanation
- Thank
Decrease in hypertension control disparity

Disparity decreased between Kaiser Permanente Southern California members whose hypertension is controlled (African-American and white)

Source: Pharmacy Analytical Service, Kaiser Permanente, Southern California – Data not yet published
Intellectual and Developmental Disabilities
Public reporting of disparities

• Should publicly reported quality measures be adjusted for race/ethnicity or socioeconomic status?
  • Readmission rates?
  • Patient satisfaction/ratings?

• There are hundreds of quality measures that are publicly reported.
  • Public reporting of quality has been associated with improvements in care
  • Public reported metrics by race/ethnicity is rarely done
Approach to disparities

• Start somewhere based on magnitude of disparity, clinical importance, and perceived ability to reduce disparity
  • Create robust measurement system
  • Use existing systems if appropriate
  • Create just culture
  • Remove any political ideology
  • Disparities reduction is a quality issue

• Be humble
Core components of success and improvement in overcoming disparities

- Actionable and current data; registries
- Clear clinical algorithms
  - With expectations that they be followed
  - Simplifying regimens to enhance patient adherence
- Clinical interventions tailored to needs and expectations of priority populations
- Dissemination and adoption of practices that make a difference in the patient experience and patient interaction
- Supporting multi-disciplinary teams to take on the issue
  - With accountabilities
- Considering and factoring in community-level education, outreach, and engagement
Conclusion

• It is possible to measure health disparities and decrease them over time.
• Medical delivery systems are just beginning this journey.
• Public reporting and transparency of disparity data could be helpful
• Every day we wait on reducing disparities, people unfairly have adverse health outcomes.