Session Objectives

- Identify the key components of an effective population management program including team-based care to address health equity.
- Implement steps to integrate Race, Ethnicity, Language Preference (RELP) Data into quality improvement programs.
- Develop culturally tailored interventions to promote coordinated, patient-centered care for racial and ethnic populations.
Our Journey from Equitable Care Health Outcomes to Health Equity

Rowena E. Bartolome, RN, BSN, PHN, MHA
National Quality Leader
Kaiser Permanente

Kaiser Permanente

- integrated health care delivery system founded in 1945
- The nation’s largest not-for-profit health plan, serving 10.6 million members, with headquarters in Oakland, CA.
- 38 Hospitals, 630 Medical Offices (ambulatory care) across 7 regions, 8 states and the District of Columbia
- 240,125 employees
  - 18,652 physicians
  - 51,010 nurses
  - 193,171 technical, administrative and clerical employees and caregivers
Kaiser Permanente Mission and Vision

- Kaiser Permanente exists to provide high-quality, affordable health care services and to improve the health of our members and the communities we serve.
- To be the leader in Total Health by making lives better.

Health Disparities Vision Statement

- Be a leader in eliminating disparities in health and health care
- Provide equitable care to our members
- Target resources to areas of need in the communities we serve
- Identify and implement strategies and policies that support equity in health nationwide, including universal coverage

Kaiser Permanente Partnership Group and endorsed by the Kaiser Foundation Health Plan/Hospitals Boards of Directors in 2007

Collection of Race and Ethnicity Data

Percent of Total Membership with Race/Ethnicity Data Entered in Kaiser Permanente HealthConnect®

Combined Race Format' Categories
- Black or African American
- Hispanic or Latino
- Asian
- Native Hawaiian or Other Pacific Islander
- American Indian or Alaska Native
- White

Ethnicity
- 268 granular ethnicities
How do we estimate race/ethnicity?

- We use the RAND Corporation’s Bayesian Improved Surname & Geocoding (BISG) methodology to estimate race/ethnicity (RE) for members without reported race or ethnicity data in the electronic health record.

  Geocoding infers RE by linking the member’s address to the racial/ethnic proportions for census block groups.

  Surname analysis infers RE from surnames, based on the U.S. Census Bureau’s national tabulation of more than 150,000 surnames, along with each surname’s self-reported RE distribution.

- For each member, an imputed racial/ethnic probability distribution is generated for these categories:
  - Black or African American only
  - Hispanic or Latino
  - White only
  - Asian or Pacific Islander only
  - American Indian or Alaska Native only
  - Multiracial

  *Non-Hispanic  **Regardless of any other racial/ethnic identity  ***Two or more racial/ethnic identities, non-Hispanic

---

Colorectal Cancer Screening for Kaiser Permanente

All members in the HEDIS denominator, stratified by a combination of reported and imputed race/ethnicity.
Framework for Team Based Care and the Patient-Centered Medical Home

Informed & Activated Patient

Pro-active Health Management and Health Care Team Model™

Health Care Team
- Primary Care Physician
- Module Front/Back Office Staff
- Support Staff
  - Advanced Practice Providers
  - Pharmacist/Nurse Practitioner
  - RN Chronic Condition Case Manager/Care Manager
  - Member Health Educator
  - Nurse Treatment Clinic Staff

Panel Management Outreach/Inreach Activities

Patient-Centered Medical Home

Model Developed by:
Rowena Bartolome, RN, PHN, MHA
KP Care Management, 9-2006, updated 2-2012
Population Care Management and Target Populations

Population Management Risk Stratification

- Self-Reported
  - Race
  - Ethnicity
  - Language Preference
  - Gender
  - Age
  - Disability Status
  - Veteran Status
  - Payer Source

Key Implementation Strategies

<table>
<thead>
<tr>
<th>Leadership</th>
<th>Data Management</th>
<th>Redesign of Health Care Delivery System</th>
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<tbody>
<tr>
<td>Mission, Vision and Goals</td>
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<tr>
<td>support and focus on Health Equity and Equitable Care</td>
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<tr>
<td>Equitable Care Health Outcomes (ECHO)- HEDIS</td>
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<td>EHR, Population Management Registries</td>
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<tr>
<td>Focus on target population and stratified by RELP</td>
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<td>Performance Reporting and Financial Incentives</td>
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<td>Health Care Team (HCT) members and Scope of Practice</td>
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<td>Decision Support Tools</td>
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<td>Assessment of Workflows</td>
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<td>Consistent Documentation</td>
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Key Implementation Strategies

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<thead>
<tr>
<th>Evidence-based Clinical Practice Guidelines</th>
<th>Culturally Responsive Care and Cultural Tailoring</th>
<th>Culturally Responsive Care and Cultural Tailoring, cont'd</th>
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<tr>
<td>• Member/Patient Education (Diet and Life Style Modification/Behavior Change, Self Management)</td>
<td>• Culturally Tailored AIDET and Four Habits Communication models to build TRUST, promote patient centered care and inclusion</td>
<td>• Unconscious Bias</td>
</tr>
<tr>
<td>• Clinician and Staff Education</td>
<td>• Race/language Concordance</td>
<td>• Patient Care Guides</td>
</tr>
<tr>
<td>• Tools and Resources</td>
<td></td>
<td>• Video-ethnography, focus groups and the voice of the member</td>
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Physician Leadership in Health Equity and Interdisciplinary Health Care Teams

Dr. Madalynne Wilkes Grundy, Family Medicine Physician
Kaiser Permanente Southern California Permanente Medical Group
Culturally Responsive Care Physician Co-Lead
What is the Business Case for Health Equity?

- Quality Care – Equitable
  - Longevity/Lives Saved
- Personalized Care/Member Satisfaction
- Affordability/Cost Saving
- Employer Marketing

KP Southern California Region Diversity & Inclusion Leadership Structure

- Executive Leadership
- Regional Physician Leaders
- Diversity & Inclusion Council
- Physician Local Champions
- Administrative Local Champions
Roles & Responsibilities

Executive Leadership

- Commitment/Sponsorship

Regional Physician Leaders

- Collaborate with other departments within the organization to reduce health inequities.
- Develop strategies for Diversity Recruitment
- Enhance the diversity, cultural competence, and performance of our physicians
- Develop Health Equity goals that are tied to financial incentives
- Oversight of Diversity and Inclusion (D&I) Council
Roles & Responsibilities

Diversity & Inclusion Council

- Share best practices to reduce health disparities
- Review Health Equity/Equitable Care Data
- Monitor Delivery of Culturally Responsive Care (CRC) and CLAS Standards
- “Train the Trainer” on facilitating physician/staff education

Roles & Responsibilities

Physician & Administrative Champion

- Leadership/MD Engagement
- Facilitate medical center physician/staff education
- Develop local strategy & communication Plan
- Ensure regulatory readiness & compliance
- Report to D&I Council
Health Equity/Equitable Care Data

KPSC CULTURALLY RESPONSIVE CARE/DIVERSITY COUNCIL STRATEGIC WORKPLAN

2016 WORKPLAN MONITORING SCORECARD

Roles & Responsibilities

- Population Care Manager/Chronic Care Disease
- Physician Engagement
  - Physician goals/data
  - Tools/Resources
  - Chronic Care Team
  - Financial Incentives
Proactive Panel Management and Interdisciplinary Health Care Teams

Anita Joshua, MPH
Senior Consultant, Complete Care Support Programs
Kaiser Permanente Southern California Permanente Medical Group
Complete Care
Every patient. Every place.
Every visit. Every time.
Every One.
Proactive Panel Management

- Standardized and centralized process where the healthcare team supports primary care physicians in managing paneled members with chronic conditions and gaps in care with customized recommendations to help close those care gaps outside of a face-to-face encounter.
  - Annually select one or more target populations for intervention region wide
Proactive Panel Management

Benefits

- Optimize care for members
  - Increase physicians’ capacity for care of chronically ill patients
  - More efficient use of physician and non-physician resources
  - Identification of and intervention on a broad range of care gaps
  - Provides care between office visits or for members not coming in regularly

- Extend physician touches with members
  - Increase patient touches: Patients report liking the support and want more
  - Increase total time with patients

- Improve clinical performance and staff efficiency

General Workflow

1. Select Trigger Population
   - stratified by key factor(s)
   - sorted by intervention needed

2. Review and take action according to intervention(s) needed

3. If needed, prepare data and/or provide recommendations and pend orders/meds for Provider review/approval

4. Provider reviews recommendations and approves/issues orders

5. Health Care Team follows up on Provider orders, ensures triaged interventions carried through and continues patient follow-up and data clean-up

Model developed by Anita Joshua
General Workflow

1. Select Target Population
   - stratified by key factor(s)
   - sorted by intervention needed

2. Review and take action according to intervention(s) needed

3. If needed, prepare data and/or provide recommendations and pend orders/meds for Provider review/approval

4. Provider reviews recommendations and approves/issues orders

5. Health Care Team follows up on Provider orders, ensures triaged interventions carried through and continues patient follow-up and data clean-up

Proactive Panel Management

Health Care Team and Structure

- Comprised of licensed (RN/PharmD/RNP) panel/care manager and unlicensed staff who work as a team to close care gaps
  - 1:10 Panel/care manager to PCP ratio (maximum)
  - 1:2 Support staff per panel/care manager (maximum)

- Standardized Workflow
  - Consistent number of charts reviewed per PCP per month and prior to meeting
  - 1-1 Monthly meetings with Health Care Team and PCP

- Use Telephone, Letter, Secure email

- Complete Care – intervene on a broad range of care gaps
Proactive Panel Management
Health Care Team Responsibilities

<table>
<thead>
<tr>
<th>Licensed Staff</th>
<th>Unlicensed Staff</th>
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<tbody>
<tr>
<td>RN, PharmD, RNP</td>
<td>PMSC, MA, Clerk</td>
</tr>
<tr>
<td>Medication Management</td>
<td>PMSC: Panel Mgmt Support Coordinator, can be MA level or LVN</td>
</tr>
<tr>
<td>Face-to-face appointment when needed</td>
<td>Schedule Appointments: Cancer Screenings, PCP Appointment</td>
</tr>
<tr>
<td>Education - Insulin</td>
<td>Reminder/Follow Up Calls</td>
</tr>
<tr>
<td>Referral to Health Education Classes</td>
<td>– Cancer Screenings</td>
</tr>
<tr>
<td></td>
<td>– Medications / Labs</td>
</tr>
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<td>Patient Lists and Reports</td>
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Benefits of Standardized, Centralized Process

- Allows us to drive processes regionally towards a common goal with greater overall improvement (target populations)
- Develop standardized tools and reports
  - Stratify and Target Specific populations
  - Cultural Tailoring
- Regular region wide virtual meetings to share information, data, best practices
  - Region wide Staff training related to selected target populations
    - E.g. Hypertension Management Updates
    - Culturally Tailored Communication Tools (AIDET)
Patient Data and Decision Support Tools Integrated Within Electronic Medical Record

Demographic information and Dates Reviewed/Re-eval

Summary of all relevant care gaps

Recommended Actions and other details to help close each care gap

Standardized Target Population Stratified Based on Care Gaps and Optimized for Scope of Practice

Patients Meeting Overall Inclusion Criteria

NON-CLINICAL INTERVENTIONS

UNLICENSED STAFF
- Non-Medication Mgmt. Related Care Gaps:
  - Need PCP Appointment
  - Lab Reminder
  - Follow up on Medication Order Pick-up

CLINICAL INTERVENTIONS

LICENSED STAFF
- Medication Management (e.g. A1C Out of Control, BP Out of Control)
# Patient Data and Decision Support Tools Customized to the Member

## Reports

- **Screening/Control Rates by Patient Ethnicity by Area/PCP**
- **MD Level Performance**
- **Outcomes Reports**
- **Productivity Reports**
Physician Level Performance Report

Outcomes Reports

Proactive Panel Management 2013 Target Populations

SPPM Patients with Diabetes AND A1c≥7

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<thead>
<tr>
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<tbody>
<tr>
<td>Oct 2013</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21.9%</td>
<td>15.9%</td>
<td>Woodward Hills (29.5%)</td>
<td>17.6%</td>
</tr>
<tr>
<td>41.2%</td>
<td>50.1%</td>
<td>Coronary (40.5%)</td>
<td>36.1%</td>
</tr>
</tbody>
</table>

Results through August 31, 2016

Living Healthy with Chronic Conditions

| % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy |
|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| A         | B         | C         | D         | E         | F         | G         | H         | I         | J         | K         | L         | M         | N         | O         | P         |
| 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0 |

Controlling High Blood Pressure (Ages 18-64)

| % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy | % Healthy |
|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|
| Total     | 84.0      | 89.4      | 89.8      | 87.1      | 86.8      | 89.6      | 89.5      | 87.9      | 86.9      | 88.8      | 89.2      | 89.8      | 88.9      | 89.2      | 88.7 |
| Change    | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0       | 0.0 |

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Health Care Team Productivity Reports

Role of Advanced Practice Providers – Pharmacists

Annet Arakelian, PharmD, FCSHP, CPHQ
Executive Director, Medicare Strategy
Kaiser Permanente Southern California Region
Recommended strategies for a pharmacy health-system in closing the healthcare disparity gap:

- Collection of self-reported RELP (Race, Ethnicity and Language), gender, age, etc., and monitoring of data on health disparities
- Effective communication to build trust and improve connections between patients and health care providers,
- Awareness of the existence of health and health care disparities
- Provision of culturally competent care and services,
- Creation of a more diverse health care work force,
- Multidisciplinary teams and evidence-based guidelines,
- Conducting research activities to evaluate strategies to address disparities in health care


Communication Strategies

The Four Habits Model

Emphasizes the vital skills of listening and demonstrating empathy by
- Investing in the beginning
- Eliciting the patient’s perspective
- Demonstrating empathy
- Investing in the end

AIDET® Communication model

The AIDET® communication model includes five steps in a communication framework
- Acknowledge
- Introduce
- Duration
- Explanation
- Thank you

The five steps help to decrease patient anxiety, to build trust and increase compliance, resulting in improved health outcomes and patient satisfaction.
Role of Advanced Practice Provider (APP)

Culturally Tailored Medication Management

“The development of intervention strategies, messages and materials to conform with specific cultural characteristics.”

Advanced Practice Pharmacist led Medication Management Group Visits

- Targeting Hypertension control:
  - High volume group visits managed by clinical pharmacist and support staff
  - Approximately 6 group visits/health fairs per year with 2 specific for Black cohort
  - Improved access (outside normal business hours, no co-pay)
  - Practice under collaborative practice agreements (medication management)
  - Individualized treatment plans thru building trust
  - On average 2-3 visits (4-6 week period) to reach blood pressure goal
Role of pharmacist in the Retail/Outpatient setting

Outpatient Pharmacy Clinical Services (OPCS)

Every pharmacy visit is an opportunity to improve outcomes

Non-adherent members identified during any outpatient pharmacy visit

Pharmacists provide face-to-face BSMART** adherence consult during Rx pick-up

Pharmacist apply a culturally tailored BSMART ** consult


Wall Street Journal - October 3, 2016
The BSMART Consultation

**Barriers:** identify barriers and assess readiness to change

**Solutions:** provide solutions to adherence challenges

**Motivation:** help patients to help themselves

**Adherence Tools:** provide tools and tips to keep patients on track

**Relationships:** identify roles of health care team members

**Triage:** direct patients to other resources in the broader health care system

Cultural Tailoring of the BSMART Consult

"the development of intervention strategies, messages and materials to conform with specific cultural characteristics"
Culturally Tailored BSMART Consult: African American/Black Population

- **Barriers**
  - Building trust is important for every encounter
  - Address the patient with formal titles (Mr., Mrs) - to convey respect for the patient and any family members brought to the consultation
  - Avoid appearing rushed - which may be viewed as discriminatory
  - Do not use “try this medication” - due to cultural fears related to experimentation
  - Include family members in consultation, if patient allows - family members play an important part in the patient’s medication adherence.
  - Assess language preference and utilize certified interpreters, not family members

Disclaimer: Culturally tailored B-SMART recommendations are excerpts from more detailed communication guides and are intended to provide basic generalization of the Hispanic and black populations to gain global understanding of the cultural preferences and health beliefs. They are not intended to promote stereotyping of individuals or groups. Healthcare providers must focus on patient-centered care to better understand the unique needs of individuals, while taking the cultural background into consideration. Hispanic and all patients must be assessed for language preference. Certified interpreters is required for LEP patients.

Culturally Tailored BSMART Consult: Latino/Hispanic Population

- **Barriers**
  - Build connections through acceptance of the individual and the culture
  - Introduce yourself as a pharmacist - Hispanic patients hold the physician and other health care providers with high esteem
  - Include immediate or extended family members in consultation, if patient allows - family members play an important part in the patient’s medication adherence.
  - Assess language preference and utilize certified interpreters, not family members
  - Encourage to ask questions - about third of Hispanic patients leave their appointments with unanswered questions

Disclaimer: Culturally tailored B-SMART recommendations are excerpts from more detailed communication guides and are intended to provide basic generalization of the Hispanic and black populations to gain global understanding of the cultural preferences and health beliefs. They are not intended to promote stereotyping of individuals or groups. Healthcare providers must focus on patient-centered care to better understand the unique needs of individuals, while taking the cultural background into consideration. Hispanic and all patients must be assessed for language preference. Certified interpreters is required for LEP patients.
Health Equity and Total Health: Beyond ECHO and Equitable Care

- Equitable Care in National Quality Strategy
  - Institute of Medicine (IOM) 6 domains: safe, effective, patient-centered, timely, efficient

- Integration with Key Stakeholders
  - Community Benefit and Community-based Activities: Social, Economic & Behavioral Needs
  - Diversity and Inclusion: "equity and inclusion for all", workforce, members with disabilities, veterans, SOGI (sexual orientation, gender identity)

Questions
“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

— Dr. Martin Luther King Jr., in a speech to the Medical Committee for Human Rights, 1966

Resources and Publications

- Frankel RM, Stein T. Getting the most out of the clinical encounter: the four habits model. Perm J 1999 Fall;3(3):79-88. DOI: http://dx.doi.org/10.7812/TPP/99-020
- Pasick, R., D’Onofrio, C., Otero-Sabogal, R., Similarities and Differences Across Cultures: Questions to Inform a Third Generation for Health Promotion Research, Health Education Quarterly. Vol. 23 (Supplement): S142-S161 (December 1996)