CoP/Training Call

A Framework for Measuring the Triple Aim, with a Special Focus on Equity and Disparities

Guest Speakers:
Kevin Nolan, MStat, MA
Matt Stiefel, MPH
Sharon Takeda Platt, PhD

May 14, 2013
2:00 PM Eastern Time
Agenda

• DNCC Update
• Training
Six Monthly Training Sessions

Module 1: Awareness
Goal: Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations

Module 2: Leadership
Goal: Strengthen and broaden leadership for addressing health disparities at all levels

Module 3: Data, Research, and Evaluation
Goal: Improve data availability, coordination, utilization, and diffusion of research and evaluation outcomes

Module 4: Health Outcomes
Goal: Improve health and healthcare outcomes for racial, ethnic, and underserved populations

Module 5: Cultural and Linguistic Competency
Goal: Improve cultural and linguistic competency and the diversity of the health related workforce

Module 6: Taking Action to Reduce Disparities
Goal: Identify specific ways to take action to improve health for underserved populations
Update from the DNCC
DNCC Updates and Activities

- **Learning Toolboxes coming soon:**
  - Awareness Toolbox released
  - Leadership
  - Minority Health Populations
  - Cultural and Linguistic Competency
- **New website:** CMS Health Disparities PULSE Resource Center
  - Administered by the DNCC
  - Going live next week!!
- **Data Release:** Hospital Acquired Infections (CLABSI, CAUTI, CDI)
New Website

CMS’ Disparities National Coordinating Center outlines a path to reducing and eliminating health and healthcare disparities.

Health Disparities Legislation & Policy

The Affordable Care Act offers the potential to address the needs of racial and ethnic minority populations, by bringing down health care costs, investing in prevention and wellness, supporting improvements in primary care, and creating linkages between the traditional realms of health and social services.

Select Your State Office of Minority Health
Dates to Remember

May 22: Post Training Review/Office Hours, 2:00 PM ET

May 24: Data Release: Hospital Acquired Infections (CLABSI, CAUTI, CDI)

June 11: Training/CoP Call: Cultural and Linguistic Competency
Guest speaker: Joseph Betancourt, Disparities Solutions Center

June 19: Office Hours: Discussion of HAI Data

July 16: Training/CoP Call: Taking Action to Reduce Disparities (New date!)
Guest speaker: Richard Hofrichter, NACCHO

July 22: Post Training Review/Office Hours
Today’s Guest Speakers

Kevin Nolan
Mstat, MA
Senior Fellow, Institute for Healthcare Improvement

Matt Stiefel
MPA
Director, Center for Population Health, Kaiser Permanente

Sharon Takeda Platt, PhD
Principal Consultant, Center for Healthcare Analytics, Hospitals, Quality and Care Delivery Excellence, Kaiser Permanente
A Framework for Measuring the Triple Aim, with a Special Focus on Equity and Disparities

Kevin Nolan
Matt Stiefel
Sharon Platt

May 14, 2013
Learning Objectives

1. Gain ideas and inspiration for measuring the Triple Aim

2. Show examples of including disparities in Triple Aim measurement
System designs that simultaneously improve three dimensions for a specified population:

- Improving the health of the population;
- Improving the patient experience of care; and
- Reducing the per capita cost of health care.
Design of a Triple Aim Enterprise

Define “Quality” from the perspective of an individual member of a defined population

Health Care  Public Health  Social Services

Individuals and Families
Definition of Primary Care
Integration
Per Capita Cost Reduction
Prevention and Health Promotion

System-Level Metrics


http://www.ihi.org/knowledge/Pages/IHIWhitePapers/AGuidetoMeasuringTripleAim.aspx
<table>
<thead>
<tr>
<th>Dimension</th>
<th>Measure</th>
</tr>
</thead>
</table>
| **Population Health**| 1. Health Outcomes:  
  - Mortality: Years of potential life lost; Life expectancy; Standardized mortality rates  
  - Health/Functional Status: single question (e.g. from CDC HRQOL-4) or multi-domain (e.g. SF-12)  
  - Healthy Life Expectancy (HLE): combines life expectancy and health status into a single measure, reflecting remaining years of life in good health  
  2. Disease Burden: Incidence and/or prevalence of major chronic conditions  
  3. Risk Status: **Behavioral risk factors** include smoking, alcohol, physical activity, and diet. **Physiological risk factors** include blood pressure, BMI, cholesterol, and blood glucose. |
| **Experience of Care**| 1. Standard questions from patient surveys, for example:  
  - Global questions from US CAHPS or How’s Your Health surveys  
  - Experience questions from NHS World Class Commissioning or CareQuality Commission  
  - Likelihood to recommend  
  2. Set of measures based on key dimensions (e.g., US IOM Quality Chasm aims: Safe, Effective, Timely, Efficient, Equitable and Patient-centered) |
| **Per Capita Cost**   | 1. Total cost per member of the population per month  
  2. Hospital and ED utilization rate and/or cost |
Figure 1. Population Health

Measures in the measurement menu in Table 1 are highlighted in **bold**
Chart 3-4. Life expectancy at birth is five years lower for blacks compared with whites.

Life expectancy in years of life remaining, 2003

<table>
<thead>
<tr>
<th></th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td>At birth</td>
<td>78</td>
<td>73</td>
</tr>
<tr>
<td>At age 65</td>
<td>19</td>
<td>17</td>
</tr>
</tbody>
</table>

Note: Based on 1990 post-censal estimates of the United States resident population.

Chart 3-2. Blacks are most likely to suffer from a chronic condition or disability.

Percentage of adults ages 18 to 64 with any chronic condition or disability, 2005

- Total: 39
- White: 40
- Black: 48
- Hispanic: 29
- Asian: 25

Note: Adults are considered to have a chronic condition or disability if they reported that a disability, handicap, or chronic disease kept them from working full-time or limited housework or other daily activities, or if they reported having diabetes or sugar diabetes, high blood pressure, asthma, bronchitis, emphysema, or other lung conditions, heart disease, heart failure, or heart attack.

Chart 3-7. Seven of 10 blacks are either overweight or obese; blacks are substantially more likely to be obese than other groups.

Percentage of adults 18 to 64 who are overweight or obese, 2006

Note: Obesity is defined as a Body Mass Index (BMI) of 30 kg/m² or more. Overweight is defined as BMI of 25 to 29.9 kg/m².
Health Outcome:
Health Status Single Question

Would you say that in general your health is: Excellent, very good, good, fair, poor

*CDC Health Related Quality of Life (HRQOL-4)*
Relationship Between Single Question and Mortality, Cost

% Fair or Poor Self Reported Health Status
Maryland

MD BRFSS
Figure 2. Drivers of Excellent Experience of Care

- Safe
- Effective
- Timely
- Patient-Centered
- Equitable
- Efficient

Specific Measures

CAHPS: How’s Your Health Likelihood to Recommend
Experience of Care: Key Dimensions - KP Example

- Clinical Effectiveness
  - Hospital Standardized Mortality Ratio
  - HEDIS Composite

- Safety
  - Never Events Composite
  - Mean days elapsed between never events by quarter

- Service
  - Health Plan Rating (%9-10)

Legend:
- Blue = Program Trend
- Purple = Region Trend
- Green = KP Target
- Black = Benchmark
- Grey Dots = Regions/Hospital

Equitable Care Legend:
- Pink = African American
- Navy Blue = Caucasian
- Aqua = Asian/Pacific Islander
- Orange = Hispanic
- Green = All Members

Service
- Health Care Rating (%8-10)
- Hospital Rating (%9-10)
“And, most important, we must build a 21st century health care system that is more equitable and meets the needs of all Americans without regard to race, ethnicity, place of residence, or socioeconomic status…”

Equitable care

Crossing the Quality Chasm: A New Health System for the 21st Century (2001)
Institute of Medicine
Kaiser Permanente’s Health Disparities Vision Statement

Kaiser Permanente will:

- 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

Adopted by the Kaiser Permanente Partnership Group and endorsed by the Kaiser Foundation Health Plan/Hospitals Boards of Directors in 2007
Collect race and ethnicity data from members

- Self-reported race/ethnicity is considered the ‘gold standard’
- Data collection is supported by the Kaiser Permanente HealthConnect Build
- **Race:** Black or African American; Hispanic or Latino; Asian; Native Hawaiian or Other Pacific Islander; American Indian or Alaska Native; White
- **Ethnicity:** 268 specific granular ethnicities

Members with Race or Ethnicity Data in Kaiser Permanente HealthConnect

<table>
<thead>
<tr>
<th>Year</th>
<th>Race/Ethnicity Data (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>31%</td>
</tr>
<tr>
<td>2009</td>
<td>39%</td>
</tr>
<tr>
<td>2010</td>
<td>47%</td>
</tr>
<tr>
<td>2011</td>
<td>73%</td>
</tr>
<tr>
<td>2012 Q3</td>
<td>78%</td>
</tr>
</tbody>
</table>
How do we estimate race/ethnicity?

- In 2008, Kaiser Permanente began using the Bayesian Improved Surname & Geocoding (BISG) algorithm, developed and validated by the RAND Corporation.

- **Geocoding** member addresses to link to Census Bureau data describing the racial/ethnic composition of census block groups.

- **Surname analysis** using the Census Bureau’s list of more than 150,000 surnames, associated with race/ethnicity and gender.
How do we estimate race/ethnicity?

- Based on surname and address, we estimate an individual’s probability distribution for standardized race/ethnicity categories:
  - Hispanic or Latino
  - Asian or Pacific Islander* 
  - Black or African American*
  - White* 
  - American Indian or Alaska Native* 
  - Multiracial*

- Probabilities are not used to describe the race/ethnicity of an individual

- We estimate the number and proportion of members in each race/ethnicity group

- Indirect methods are widely used: Aetna, CIGNA, Harvard Pilgrim, HealthPartners, Humana, UnitedHealth Group, and WellPoint

*Non-Hispanic
### Equitable care measures, tracked quarterly

<table>
<thead>
<tr>
<th>Prevention and Screening Measures</th>
<th>Process of Care Measures</th>
<th>Intermediate Outcome Measures</th>
<th>Strategic HEDIS Subscale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast cancer screening</td>
<td>Cholesterol management for patients with cardiovascular conditions: LDL-C screening</td>
<td>Cholesterol management for patients with cardiovascular conditions: LDL-C control &lt; 100</td>
<td></td>
</tr>
<tr>
<td>Cervical cancer screening</td>
<td>Persistence of beta-blocker treatment after a heart attack</td>
<td>Controlling high blood pressure (patients with hypertension)</td>
<td></td>
</tr>
<tr>
<td>Colorectal cancer screening</td>
<td>Comprehensive diabetes care: HbA1c testing</td>
<td>Comprehensive diabetes care: HbA1c control &lt; 9.0%</td>
<td></td>
</tr>
<tr>
<td>Childhood immunization status: combination 3</td>
<td>Retinal eye exam</td>
<td>LDL-C screening</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical attention for nephropathy</td>
<td>Medical attention for nephropathy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>BP control &lt; 140/90</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The “big dot” measure for equitable care is the unweighted average of the administrative rates for all of the equitable care measures, except childhood immunization status</td>
<td></td>
</tr>
</tbody>
</table>
Colorectal Cancer Screening, by Race/Ethnicity
Kaiser Permanente Programwide

- All Members
- Black or African American
- Asian or Pacific Islander
- Hispanic or Latino
- White
- HEDIS Natl 90th Pctile
Controlling High Blood Pressure, by Race/Ethnicity
Kaiser Permanente Programwide

- All Members
- Black or African American
- Asian or Pacific Islander
- Hispanic or Latino
- White

HEDIS Natl 90th Pctile
## Members

- Date of birth
- Gender
- Marital status
- Race
- Ethnicity
- Primary spoken and written languages
- Interpreter needed
- Geocoded address
- Distance to the closest Kaiser Permanente medical offices

## Where Our Members Live

- Average household size
- Median age
- Population by age
- Population by race
- Population per square mile
- Per capita income
- Population by household income
- Median household income
- Population by educational attainment
- Unemployment rate
Maps for equitable care measures

Colorectal Cancer Screening Hot/Cold Spots & Hispanic/Latino KP Member Density 2012 Q1

Colorectal Cancer Screening
Red = Significantly Lower Rates
Blue = Significantly Higher Rates

Low
Avg
High

KP Member Dot Density
1 Dot = 500
Hispanic / Latino
non-Hispanic / Latino

Medical Office Building
KP MOB

County Health Rankings: Mobilizing Action Toward Community Health: [http://www.countyhealthrankings.org/](http://www.countyhealthrankings.org/)


Crossing the Quality Chasm: A New Health System for the 21st Century (2001) - Institute of Medicine

Health Partners: Total Cost of Care – [www.healthpartners.com/tcoc](http://www.healthpartners.com/tcoc)
Q&A

Press 14 to enter the queue to ask a question.
After Today’s Webinar

Evaluation

• Evaluation: Please fill out our evaluation at the end of today’s call. Questions will also be sent via listserve.

Slides, recording, and transcript will be posted online.

• www.healthcarecommunities.org

Post-Training Review/Office Hours

• May 22\textsuperscript{nd}, 2:00 ET

• This is an opportunity to discuss today’s presentation topic with guest speakers and fellow QIOs.
Join the DNCC Community

To Join the DNCC Listserve:

• Log onto the SDPS system.
• Open Internet Explorer. Your default homepage should be qionet.sdps.org.
• At the top of the page, you should see a tab labeled “Listserve.” Click “Listserve.”
• Enter your user information at the top of the page and scroll down to “Disparities”. Join “Discussion” and “Notify”.
• Click “Subscribe”.

To Join DNCC Healthcare Communities:

• Log onto www.healthcarecommunities.org
• Sign in, or create an account.
• Scroll over the “Communities” tab, scroll down to “Available Communities” and select “QIO 10TH SOW”.
• Scroll down to DNCC and select “Join DNCC”.
Thank you for participating in today’s webinar.

At the close of the presentation, you will automatically be directed to an evaluation screen.